EAST SUSSEX HEALTH AND WELLBEING BOARD

TUESDAY, 27 JUNE 2023

2.00 PM COUNCIL CHAMBER, COUNTY HALL, LEWES

MEMBERSHIP -	Councillor Keith Glazier, East Sussex County Council (Chair) Councillor Carl Maynard, East Sussex County Council Councillor John Ungar, East Sussex County Council Councillor Trevor Webb, East Sussex County Council Councillor Margaret Bannister, Eastbourne Borough Council Councillor Teresa Killeen MBE, Rother District Council Jessica Britton, NHS Sussex Dr Stephen Pike, NHS Sussex Vacancy, NHS Sussex Mark Stainton, Director of Adult Social Care Darrell Gale, Director of Public Health Alison Jeffery, Director of Children's Services Veronica Kirwan, Healthwatch East Sussex Joanne Chadwick-Bell, East Sussex Healthcare NHS Trust
INVITED OBSERVERS WITH SPEAKING RIGHTS	Councillor Andy Batsford, Hastings Borough Council Councillor Paul Davies, Lewes District Council Becky Shaw, Chief Executive, ESCC John Willett, Sussex Police and Crime Commissioner Mark Matthews, East Sussex Fire and Rescue Service Geraldine Des Moulins, Voluntary and Community Sector representative

A G E N D A

1. Minutes of meeting of Health and Wellbeing Board held on 7 March 2023 *(Pages 3 - 8)*

2. Apologies for absence

3. Disclosure by all members present of personal interests in matters on the agenda

4. Urgent items

   Notification of items which the Chair considers to be urgent and proposes to take at the end of the agenda. Any members who wish to raise urgent items are asked, wherever possible, to notify the Chair before the start of the meeting. In so doing, they must state the special circumstances which they consider justify the matter being considered urgently

5. Draft Sussex Integrated Care Strategy Shared Delivery Plan (SDP) *(Pages 9 - 100)*

6. Better Care Fund Plans 2023-25 *(Pages 101 - 170)*

7. East Sussex Public Health and Planning Memorandum of Understanding (MOU) *(Pages 171 - 196)*

8. Pharmacy Closures in East Sussex - Update report *(Pages 197 - 206)*

9. Work programme *(Pages 207 - 208)*

10. Any other items previously notified under agenda item 4

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19 June 2023

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EAST SUSSEX HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the East Sussex Health and Wellbeing Board held at Council Chamber, County Hall, Lewes on 7 March 2023.

MEMBERS PRESENT	Councillor Keith Glazier (Chair) Councillor John Ungar, Councillor Andy Batsford, Jessica Britton, Dr Stephen Pike, Mark Stainton, Darrell Gale, Alison Jeffery, John Routledge and Joanne Chadwick-Bell
INVITED OBSERVERS PRESENT	Councillor Emily O'Brien and Councillor John Barnes MBE
Presenting Officers	Vicky Smith, Programme Director - East Sussex Health and Social Care Transformation Lisa Emery, Chief Transformation, Innovation and Digital Officer, NHS Sussex John Routledge, Healthwatch East Sussex Anna Hoad, Healthwatch East Sussex

32. MINUTES OF MEETING OF HEALTH AND WELLBEING BOARD HELD ON 13 DECEMBER 2022

32.1 The minutes of the meeting held on 13 December 2022 were agreed as a correct record.

33. APOLOGIES FOR ABSENCE

33.1 The following apologies for absence were received from members of the Board:

- Councillor Carl Maynard, East Sussex County Council
- Councillor Trevor Webb, East Sussex County Council
- Councillor Pam Doodes, Wealden District Council
- Veronica Kirwan, Healthwatch East Sussex

33.2 The following substitutions were made from members of the Board:

- John Routledge substituted for Veronica Kirwan

33.3 The following apologies for absence were received from invited observers with speaking rights:

- Becky Shaw, East Sussex County Council
- Councillor Peter Diplock, Eastbourne Borough Council
- Mark Matthews, East Sussex Fire and Rescue Service
- John Willett, Sussex Police and Crime Commissioner

34. DISCLOSURE BY ALL MEMBERS PRESENT OF PERSONAL INTERESTS IN MATTERS ON THE AGENDA

34.1 There were no disclosures of interests.

35. URGENT ITEMS

35. 1 There were no urgent items.

36. INTEGRATION PROGRAMME AND SHARED DELIVERY PLAN DEVELOPMENT UPDATE

36.1 The Board considered an update report on the East Sussex Health and Social Care Integration Programme and the development of a Shared Delivery Plan (SDP) for the NHS Sussex Integrated Care Strategy (ICS). The SDP brings together immediate health and social care system priorities around access to services and the co-ordination of prevention services.

36.2 The Board commented that the report was well put together and meaningful and stressed the importance of getting the approach right to ensure collaborative working across all the partners. The Board asked a number of questions about the report which are summarised below.

36.3 In terms of improving health outcomes, the Board asked why there were no crosses against preventable sight loss under the frailty category in the table identifying high level of need by place, according to the East Sussex public health outcomes framework (appendix 4, page 49 of the report).

36.4 Vicky Smith, Programme Director, East Sussex Health and Social Care Transformation responded that she thought this was an oversight and will investigate and arrange for it to be corrected as necessary.

36.5 Councillor Batsford commented that he thought there should be more focus on health inequalities in places such as Hastings where there are some of the poorest areas in East Sussex and there are high levels of need. The Chair commented that the focus of the report is on health inequalities which the SDP is seeking to address.

36.6 The Board sought reassurances that the approach to health inequalities would take into account the areas throughout the county where there are areas of greater inequality. The Board also asked if the proposed workshops would use an analysis of information that has previously been gathered as a basis for asking further questions, rather than asking open questions that we might already know the answers to.

36.7 Vicky Smith outlined that the priorities identified in the Improving Health Outcomes: Summary of Opportunities Analysis (appendix 4 of the report) is a summary that brings together public health information on the four conditions (CVD, Mental Health, Respiratory and Frailty) which are being used as indicators of poor health. They are then being used as a lens to focus on areas of work where there are opportunities for prevention and other work where change is possible. It aims to show where there might be outliers in health outcomes compared with the England average, including within Borough and District council communities, which might need to be explored in more detail. This is also why there is an integrated community team approach to the work to examine these differences and produce an integrated plan based on community intelligence and insight.

36.8 The intention is to develop a set of co-designed workshops which will bring together all the expertise that people and communities have on their local areas as well as the information clinicians and health professionals have. The plan is to refresh the approach and bring together

intelligence and insight, and link this to measurable outcomes for population health and more immediate actions for within year activity.

36.9 The Board asked who in the NHS and Social Services are ultimately accountable as shown in the simplified governance structure for the development and sign off of the Integrated Care Strategy (page 20 of the report).

36.10 Mark Stainton, Director of Adult Social Care and Health responded that the ultimate accountability does not lie in one place, as the ICS brings together a whole range of health and care organisations. For provider Trusts they are accountable to the NHS Sussex Board (ICB); for East Sussex County Council (ESCC) services they are accountable to local people through the Lead Member, Cabinet and Health and Wellbeing Board (HWB); and as a system the accountability is to the Sussex Health and Care Assembly which is pan Sussex and includes the Chairs of three Sussex HWBs, senior council officers, non-executive members and officers of NHS Sussex. The diagram on page 20 of the report attempts to show these different governance arrangements. Neither the Health Overview Scrutiny Committee nor the HWB are a sub-set of ESCC, and the diagram is attempting to show where local government governance sits.

36.11 Alison Jeffery, Director of Children's Services commented that she was really keen on the SDP having a bigger focus on children and young people in East Sussex. When it comes to prevention and investment in services it will be important to invest in services such as those for mental health.

36.12 The Board RESOLVED to:
1) Note the progress with planning to support our implementation of the shared ambition and priorities set out in the Sussex Integrated Care Strategy and joint East Sussex Health and Wellbeing Board Strategy;
2) Endorse the direction of travel and the recommended planning milestones for2023/24, which will also form the basis of the East Sussex Place contribution to the Sussex Shared Delivery Plan (SDP), and;
3) Agree to explore holding a meeting of the HWB in June 2023 in order to come to a view on whether the SDP takes account of HWB Strategy priorities, and enable the requirements of the HWB and timescales set by NHS England as outlined in paragraphs 2.4 – 2.7 to be met.

37. HEALTHWATCH EAST SUSSEX - EASTBOURNE LISTENING TOUR REPORT

37.1 The Board considered a report on the Eastbourne Listening Tour carried out by Healthwatch East Sussex in October 2022. The report includes the findings and the recommendations made as a result of the work undertaken on the Listening Tour.

37.2 The Board noted the comments regarding access to GPs in the report and observed that it is important to keep people informed on the challenges facing GP practices and to give feedback to the public regarding improvements to, or developments in, the service.

37.3 The Board asked how the headline findings in the report, such as access to services and confidence in services, compare with other places.

37.4 John Routledge, Healthwatch East Sussex responded that generally concerns expressed about access to GPs and dentistry are similar to other areas. Some services such as dentistry attract more concerns because when you need to access dentistry services there are no alternatives. Over the last few years concerns about access have increased, including access to face to face appointments with GPs. The main concerns are about access rather than the service itself once people have been able to access treatment. Anna Hoad, Healthwatch

East Sussex added that the report also contains links to more detailed reports that provide a further breakdown of the feedback received from the Listening Tour.

37.5 The Board asked if the responses reported from the listening tour were people's direct experiences of services.

37.6 John Routledge clarified people were asked "in your experience, or someone you care for", in order to capture people's direct experience of services when asking for people's views about services.

37.7 The Board asked if the Healthwatch report would lead to further action as the HWB was being asked to note the report.

37.8 Joe Chadwick-Bell, Chief Executive, East Sussex Healthcare NHS Trust (ESHT) commented that it is right to look at services in detail, but it should be remembered that the Listening Tour was carried out during a difficult period for the NHS when there were pressures on services and staff, and the recovery from backlogs built up during the Covid pandemic. It is possible to demonstrate where people are accessing care, such as cancer referrals, and it is important that people are coming forward for the services they need.

37.9 Jessica Britton, Executive Director, NHS Sussex added that it is helpful to get the report and details of people's experiences which focuses on areas of concern and access to services. It reflects areas where the NHS knows there is more work to do. The NHS will look at the recommendations to inform its work, and they will feed into work programmes to make improvements through the Health and Care Partnership.

37.10 Mark Stainton added that the report contained some really useful information, and the report covers areas where some research has already been undertaken and other areas that are new. He suggested the next steps would be to take the report to either the East Sussex Health and Care Partnership or to the East Sussex Health and Care Partnership Executive, to consider the recommendations for individual organisations and those for the broader health and care system.

37.11 Anna Hoad commented that Healthwatch would be happy to follow this up and provide more detailed reports where that would be helpful. The Chair added that it was a really helpful report and the next steps for the report would be to refer it to the East Sussex Health and Care Partnership.

37.12 The Board RESOLVED to:
1) Note the report; and
2) Refer the outcomes of the Healthwatch East Sussex, Eastbourne Listening Tour to the East Sussex Health and Care Partnership for their consideration.

38. BUILDING FOR OUR FUTURE AND ESHT HOSPITAL REDEVELOPMENTS

38.1 The Board considered a report on the Building For Our Future programme and ESHT hospital redevelopments. ESHT is in cohort four of the Government's New Hospitals Programme.

38.2 The Board asked if there would be a new hospital in Eastbourne.

38.3 Joe Chadwick-Bell responded that the national definition of a new hospital includes a completely new build hospital, or a significant extension, or a significant redevelopment of an existing hospital (e.g. redesign of the interior). At this stage ESHT cannot tell which it will be as

it does not know how much funding has been allocated. Once ESHT knows what the funding will be, it can give a better indication of the future for the Eastbourne hospital.

38.4 The Board asked how patients from Hastings would be able to access the new Elective Surgery Hub at Eastbourne and whether Hastings would get a diagnostic hub.

38.5 Joe Chadwick-Bell outlined that outpatient appointments would continue to be provided at both Hastings and Eastbourne hospital sites. Day case surgery will also continue to be provided at both sites so people will have a choice. The new Elective Hub will provide more capacity for procedures and reduce wating times. Access to the new Elective Hub will be via referrals. A new Travel Liaison Officer post (which is being provided as part of the Cardiology and Ophthalmology transformation proposals) will be able to help with transport and support arrangements for patients. If patients are eligible for the Patient Transport Service, they will get transport to the new Elective Hub.

38.6 Jessica Britton commented that a range of options were being considered for a diagnostic hub in Hastings. The New Elective Hub will mean additional capacity to carry out minor procedures and it will still be possible to have procedures at both Hastings and Eastbourne. There will continue to be patient choice in terms of where people have their procedure and there will be support provided for transport and access to the new Elective Hub.

38.7 Councillor Batsford asked if Hasting Borough councillors and Council could be kept updated about the proposals for a new diagnostic hub. Jessica Britton confirmed that Hastings Council and councillors would be included in any communications about the new diagnostic hub.

38.8 The Board RESOLVED to note the update on the status of East Sussex Healthcare NHS Trust's capital developments and plans for hospital redevelopment as part of the Government's New Hospitals Programme.

39. PHARMACY PROVISION IN EAST SUSSEX

39.1 The Board considered a report on Pharmacy provision in East Sussex following the notification by LloydsPharmacy that it was closing three 100 hour pharmacies located in Sainsbury's supermarkets in St. Leonards on Sea, Newhaven, and Hampden Park in Eastbourne.

39.2 The Board commented that the closures would mean a substantial amount of out of hours access to pharmacies would be lost. Dr Stephen Pike also raised concerns about the loss of acute access to pharmacies (e.g. the Newhaven pharmacy provides medicines for end of life care) and commented that overall activity can mask individual patient need.

39.3 The Board asked if a reason had been given for the closures.

39.4 Darrell Gale, Director of Public Health responded that a reason had not been given by Lloyds for the closures, and this was a Lloyds decision rather than a decision by Sainsbury's where the pharmacies are located. It may be a reflection of decisions being made by Lloyds about their pharmacy business, and it is understood that the future of Lloyds pharmacies located in Ringmer, Newick, Forest Row and Sidley are also under discussion. *(Post meeting note: It has been clarified that LloydsPharmacy is reviewing its community pharmacy estate and is selectively selling some branches. There have been no notifications of any closures in East Sussex other than the three within Sainsbury's).*

39.5 Councillor O'Brien expressed concern about the closures as this would leave the Lewes district without out of hours provision and Newhaven is an area where there is a greater mental health need.

39.6 The Board asked about the process if option 2 to issue a Supplementary Statement to the Pharmaceutical Needs Assessment (PNA) is taken. Would this lead to the commissioning of replacement pharmacy services.

39.7 Darrell Gale outlined that the process would be to look at the PNA to check the demographic information and to establish where 100 hour (extended hours) pharmacy services needed to be commissioned. There will then be some consultation and engagement work before making a recommendation to the HWB and work with NHS England to commission the new/replacement services. It was clarified that there will be NHS commissioning funding to pay for new/replacement pharmacy services. This may also be of interest to new health centres if they could help with pharmacy provision.

39.8 The Board RESOLVED to:
1) Note the impact on pharmaceutical provision in East Sussex of the Lloyds Pharmacy decision to close its outlets in Sainsburys stores; and
2. Agree to Option 2 and to the issuing of a supplementary statement of the East Sussex Pharmaceutical Needs Assessment.

40. WORK PROGRAMME

40.1 The Board discussed the work programme and the need to hold an additional meeting towards the end of June 2023 to consider the NHS Sussex ICS Shared Delivery Plan (SDP). It was suggested that the additional meeting could be held on 27 June 2023 and the items currently scheduled for the 18 July meeting could be split across the agendas for the two meetings.

40.2 The Board RESOLVED to note the work programme and agree to hold an additional meeting in June 2023 to consider the SDP.

41. ANY OTHER ITEMS PREVIOUSLY NOTIFIED UNDER AGENDA ITEM 4

41.1 There were none.

The meeting ended at 4.00 pm.

Councillor Keith Glazier (Chair)

Report to: **East Sussex Health and Wellbeing Board**

Date of meeting: **27 June 2023**

By: **Executive Managing Director, East Sussex, NHS Sussex and Director of Adult Social Care and Health, East Sussex County Council**

Title: **Draft Sussex Integrated Care Strategy Shared Delivery Plan (SDP)**

Purpose: **To enable consideration of the draft joint Sussex Integrated Care System (ICS) Shared Delivery Plan (SDP) as it relates to delivering the agreed priorities for the population of East Sussex in the East Sussex Health and Wellbeing Board Strategy and Sussex Integrated Care Strategy.**

RECOMMENDATIONS:

East Sussex Health and Wellbeing Board is recommended to:

1) **Endorse the East Sussex milestone plans that will enable delivery of East Sussex population and Place priorities, as set out in Delivery Area 4 of the SDP, and the collaborative arrangements in East Sussex to support delivery (in paragraphs 2.11 – 2.16 of the report) and;**
2) **Endorse the draft SDP as set out in Appendix 1 and agree that the Health and Wellbeing Board submits a statement of support, prior to the SDP being submitted to NHS England (NHSE) and the NHS Sussex Integrated Care Board (ICB)**

1. Background

1.1 The Sussex Integrated Care Strategy *Improving Lives Together* builds on our East Sussex Health and Wellbeing Strategy *Healthy Lives, Healthy People* (2022 – 2027), and sets out our ambition for a healthier future for everyone in Sussex over the next five years. Within the Strategy, the Assembly identified the following key strategic priorities:

- Maximising the potential of partnerships and a new joined-up community approach, through strengthening Place-based partnerships and the development of Integrated Community Teams
- Growing and supporting our Sussex health and care workforce
- Improving the use of digital technology and information

1.2 The approach will have a greater focus on keeping people healthy, supporting all aspects of people's lives and the specific needs of children and young people, as well as living well and ageing well as adults and having a good end of life.

1.3 To support the subsequent delivery planning process, the national Guidance for developing a five year 'Joint Forward Plan' (JFP) was published by NHS England (NHSE) in December 2022, setting out the key requirements and areas of flexibility for Integrated Care Boards (ICBs), their partner Trusts and system partners to bring together a first draft JFP before the start of the 2023/24 financial year. NHSE also published the NHS Operational Planning Guidance for 2023/24 at the same time covering NHS operational priorities including primary care, urgent and emergency care, planned care and hospital discharge, to ensure links could be made between the two planning processes by ICBs.

1.4 To meet the national timescales, a 5-year joint plan, known in Sussex as the Shared Delivery Plan (SDP), has been brought together in two phases. A first draft Plan was endorsed by the Sussex NHS Integrated Care Board (ICB) on 29 March 2023 for further development, which covered initial milestones for year 1 (2023/24). A full finalised Plan will be submitted to

NHSE by 30 June covering the additional high-level milestones for years 2-5 (2024/25 – 2027/28), and presented to the NHS Sussex Integrated Care Board (ICB) on 5 July for approval.

1.5 A core principle for this joint work is that the primary building blocks are the three "Places" (East Sussex, West Sussex and Brighton and Hove). At the inception of the Sussex ICS there was local agreement that "Place" is key to strategic leadership, local commissioning and delivery within the ICS, in order to get the best value out of the full range of collective resources available to meet needs and improve the health, care and wellbeing of populations.

1.6 This approach was strongly endorsed, together with the need for more local flexibility from the NHS at a local level, by the Hewitt Review. On 14 June 2023 the Government published a combined response to both the Hewitt Review recommendations (published on 4 April 2023) and the House of Commons Health and Social Care Committee's Seventh report - Integrated care systems: autonomy and accountability as a result of their inquiry on ICSs (published on 30 March 2023) due to their overlapping themes. A fuller digest of the response will be completed, and some summary headlines are:

- Agreement with the reduction of the number of overarching national targets imposed on ICSs, which will empower them to focus on priorities in their local areas.

- Development of a shared outcomes toolkit that will support places to develop their own robust shared outcomes, with priorities and metrics that are directly linked to the needs of their populations.

- Recognition of the importance of prevention to reducing overall demand on services, and that overtime the focus of the NHS should increasingly shift towards implementing interventions to help improve prevention and support healthier life expectancy, rather than imposing a national expectation of a shift in spending in line with the 1% (at least) over the next 5 years recommended by the Hewitt Review.

- Confirmation that the future assessments of the effectiveness of ICS partnership working across the ICS will be undertaken by the Care Quality Commission (CQC).

1.7 The national Joint Forward Plan Guidance also outlines a key statutory role in the SDP development process for HWBs to be consulted for their opinion on whether the draft SDP takes proper account of HWB Strategies. To support this, at the last meeting of the HWB on 7 March 2023, it was agreed to arrange an extra meeting of the HWB in June. Details about the opinion of HWBs and how the SDP has responded should be included in the final draft plan that will be submitted in June.

1.8 In light of this specific role and the timescales outlined in paragraph 1.4, this report provides an update on the progress made with producing the Integrated Care Strategy SDP, and the role of the East Sussex Health and Care Partnership which brings together NHS partners with East Sussex County Council (ESCC), and Borough and District Council, Healthwatch and VCSE representation, and will be responsible for delivering the East Sussex HWB Strategy elements in the SDP, accountable to the HWB. This will enable due consideration to be given to the final draft Sussex SDP and its content, as it relates to delivering our shared priorities for the population of East Sussex, prior to submission to NHSE and NHS Sussex ICB.

2 Supporting information

Sussex Shared Delivery Plan (SDP)

2.1 A core programme team within NHS Sussex has managed and coordinated the process of drawing the SDP together. At ICS level the Senior Responsible Officer for this work is the NHS Sussex Chief Transformation, Innovation and Digital Officer (CTIDO). The SDP has been written

as a single plan that incorporates the NHS Operating Plan requirements for 2023/24 and the delivery plan for the five-year Sussex *Improving Lives Together* Strategy.

2.2 The full draft Sussex SDP is attached at **Appendix 1**. It brings together into one place the strategic, operational and partnership work that will take place across our system to improve health and care in Sussex over both the short and long term. It also reflects and responds to national policy and guidance. In summary, it set out actions across four main delivery areas:

- Delivery Area 1: Delivering our **long-term** improvement priorities, including the three strategic priorities of the Sussex Integrated Care Strategy for a joined up approach in communities, workforce and improving the use of digital technology and information.

- Delivery Area 2: Making **immediate** improvements to services, focussed on areas that need the most improvement across primary care; urgent and emergency care; diagnostic and planned care waiting lists, and; accelerating patient flow through, and discharge from, hospital.

- Delivery Area 3: areas that need **continuous** focus and improvement across health inequalities; mental health; learning disability and autism; clinical leadership, and; making the best use of resources.

- Delivery Area 4: Delivering **Health and Wellbeing Strategies** and the work of the Place-based partnerships in Brighton & Hove, East Sussex and West Sussex

2.3 Across all delivery areas the SDP aims to set out a comprehensive response to the Sussex Integrated Care Strategy based on the needs of the population of Sussex, which is built on the three local Joint Strategic Needs Assessments (JSNAs) and HWB Strategies. Delivery Area 4 contains the primary shared delivery milestones that are unique to East Sussex, based on the shared understanding of the needs and priorities for our population, alongside those for West Sussex and Brighton and Hove. This aligns with Sussex wide delivery priorities in Delivery Area 1 agreed through the Sussex Strategy, in particular the development of Integrated Community Teams.

2.4 Delivery Areas 2 and 3 are focussed on areas that are operational priorities for immediate and continuous improvement for the NHS. There will also be key interfaces with ESCC Adult Social Care, Public Health and Children's Services and other partners within these Delivery Areas, where we would be seeking to maximise the benefit of partnership working with the NHS for the heath, care and wellbeing of our population in line with our wider HWB Strategy priorities.

2.5 To support the delivery of the ambition and the four delivery areas, there are other areas that will require continued focus, either as part of specific improvement actions or as distinct pieces of work. In summary these are as follows:

- Prevention
- Maternity and Neonatal Care
- Safeguarding
- Quality
- Supporting social and economic development
- Climate change commitments
- Evidence, research and change methodology

East Sussex shared delivery priorities

2.6 Our shared strategic priorities and objectives for health and care integration are set out in our East Sussex HWB Strategy (2022 – 27). This helped inform the Sussex *Improving Lives Together* Strategy that was endorsed and approved by the HWB and Sussex Health and Care Assembly respectively in December 2022.

2.7 The direction of travel for year 1 (2023/24) East Sussex delivery priorities and milestones was endorsed by the East Sussex HWB on 7 March as the basis of the East Sussex Place contribution to the initial draft Sussex Shared Delivery Plan (SDP). This was submitted by the ICB to NHS England (NHSE) at the end of March for their early review, and the milestones were subsequently further developed.

2.8 Planning for years 2 – 5 has subsequently taken place to finalise the East Sussex contribution to the full SDP. This included further updates to our year 1 milestones and the high-level roadmap for years 2-5 (2024/25 – 2027/28) across our priorities in the HWB Strategy in the following areas:

- Population health and reducing health inequalities;
- Children and Young People;
- Mental Health, and;
- Community

2.9 The draft East Sussex delivery priorities and high-level milestones in Delivery Area 4 cover existing ongoing work and the alignment of local work to support delivery of Sussex-wide programmes, for example the hospital discharge frontrunner programme. In addition, as discussed at the HWB meeting on 7 March, some new priorities and milestones for delivery have been shaped by our East Sussex Health and Care Partnership. These are designed to increase the pace of our partnership activity in the following areas:

- Accelerating **health outcomes improvement**, specifically focussed on cardiovascular disease (CVD), respiratory disease, mental health (all ages) and frailty/healthy ageing. This will be achieved in 2023/24 through co-designing and delivering whole system pathway improvement action plans for CVD, respiratory disease, mental health and frailty/healthy ageing, in line with the high-level timeline and milestones set out in the SDP.

- Our model for delivering **integrated health, care and wellbeing in communities** and progressing the integrated community team 'proof of concept' exercise in Hastings. Initially this will be through building on our original integrated community health and care services target operating model (TOM) and existing related project and learning activity in Hastings, for example the Universal Healthcare proposition. The in-year milestones will enable us to test and develop our approach to ensure primary care, mental health and other services that impact on the wider determinants of health are a part of the model. Planning for further phases of activity will then take place to roll the model out across the county, in line with the high-level roadmap set out in the SDP.

2.10 The high level milestones in Delivery Area 4 of the draft SDP that the East Sussex Health and Care Partnership will be responsible for leading have been further developed and shaped, together with an in-year timeline for 2023/24. A progress report across all the East Sussex delivery priorities for 2023/24 will be brought to the July meeting of the HWB.

Governance arrangements to support delivery

2.11 The proposed delivery arrangements across all four Delivery Areas are set out in the SDP, including proposals to manage eleven workstreams at a Sussex level. Each of the long-term, immediate, and continuous improvement priorities set out in Delivery Areas 1, 2 and 3 will be led by a Delivery Board, chaired by a system Chief Executive Officer, and they will have a workstream that will be resourced from across system partners. The work of these Boards and workstreams will be overseen by a System Oversight Board, chaired by the Chief Executive Officer of NHS Sussex. The Boards will address the needs of the whole population of Sussex. To ensure that there is a clear focus on the needs of children and young people, the ICS Children and Young People Board will contribute to and advise the work of each of the Delivery Boards to ensure that those needs are well addressed.

2.12 At Place level within the ICS, the three HWBs and existing Health and Care Partnerships bring together NHS partners, local authorities and the VCSE sector to further develop our integrated approaches to planning, delivering and transforming services, and to improve population health through delivery of Health and Wellbeing Strategies and associated plans.

2.14 The Health and Wellbeing Strategies and Place-based Partnership priorities specific to each Place (Delivery Area 4) will be delivered through agreed programmes of work, overseen and managed at Place level through the three Health and Care Partnerships. Shared governance and senior responsible officer arrangements drawn from our organisations are in place to monitor delivery, with mutual accountability to Health and Wellbeing Boards for delivering joint Local Authority and NHS plans. These Place arrangements will also support coordination and alignment of local implementation across all four Delivery Areas in the Shared Delivery Plan, where this is needed.

2.15 In line with this the East Sussex Health and Care Partnership will coordinate leadership of Delivery Area 4 across all partners in East Sussex, including the County Council, NHS Sussex, East Sussex Healthcare NHS Trust, Sussex Community NHS Foundation Trust and Sussex Partnership NHS Foundation Trust, and our wider system partners including Primary Care Networks, the East Sussex Voluntary, Community and Social Enterprise (VCSE) Alliance, Healthwatch and our Borough and District Councils.

2.16 To support this we have reviewed and refreshed our existing Place-based East Sussex Health and Care Partnership and programme governance structure to ensure it is fit for purpose, and can best enable the collective leadership required at Place level to deliver our Shared Delivery Plan milestones. The refreshed streamlined governance structure and detail is contained in **Appendix 2**. In summary this includes:

- A shared focus on collective strategy and impacts for our population through the East Sussex Health and Care Partnership Board and accountability to the HWB.
- A clear focus on implementation and delivery at Place level within our ICS through the East Sussex Health and Social Care Executive Delivery Group. This includes ensuring robust connections with the new Sussex-wide Delivery Boards where appropriate.
- Proposals to bring together our existing Planned Care Oversight Board and Population Health, Prevention and Health Inequalities Steering Group into a single new Health Outcomes Improvement Oversight Board, with responsibility for the new programme of work to deliver service and pathway improvements across CVD, respiratory, mental health and frailty/healthy ageing.
- Each programme Oversight Board providing a continuing focus on facilitating the local planning, commissioning, delivery and service transformation required to deliver improved health outcomes, integrated services and care for children and young people and mental health, and integrated community teams for health, care and wellbeing. This includes ensuring strong connections and alignment with Sussex-wide Delivery Boards and programmes where appropriate.
- Ensuring a local implementation focus on Sussex-wide programmes for urgent and emergency care through the existing local and developing Sussex-wide arrangements, to ensure this meets the needs of our population and fits with local provider arrangements. OPEX and the Executive Delivery Group will enable appropriate alignment of Sussex-wide delivery on the ground.
- Instigating a new 'Population Health and Care Intelligence Steering Group' to enable our Oversight Boards, programmes and systems locally to be guided by the right intelligence, insight and evidence about our population, and learning about what works.

Patient and public engagement

2.17 National guidance made clear that in the development of the SDP, existing patient, public and workforce insight and feedback should be drawn upon to inform development of the plan. As part of the development of the Sussex Improving Lives Together Strategy, the engagement approach successfully delivered direct feedback from 18,000 people, face to face and virtual

workshops with 420 people, 500 interviews and direct feedback through partners, 1440 survey responses on our ambition priorities, 800 individual conversations in public engagement events and online communication that reached more than 200,000 people.

2.18 In addition to the extensive engagement already drawn upon in the development of the Sussex Strategy, an Engagement Planning Oversight Group has been established to ensure that insight from people and communities is appropriately and satisfactorily represented in the plan. The Group will also ensure that there is an ongoing commitment to, and arrangements for, engagement with people and communities across the SDP. The membership of that group includes Healthwatch in Sussex, the voluntary, community and social enterprise sector, and Community Ambassadors alongside others.

Views of the East Sussex Health and Care Partnership Board

2.19 Members of the East Sussex Health and Care Partnership Board considered the full draft SDP at their meeting on 2 June, and how well it aligns with and supports delivery of our ambitions, priorities and plans for our population of East Sussex as set out in our East Sussex HWB Strategy. Members of the Partnership Board also considered the proposed refresh of our partnership and programme governance, to ensure it will support effective collaboration at Place level to enable delivery of the SDP.

2.20 The members of the Partnership Board endorsed the content of the SDP as it relates to East Sussex. It was also felt that the Place governance refresh will enable an ongoing focus on local needs and priorities building on our existing partnership working, balanced with a Sussex-wide approach that will further support the momentum and pace necessary for delivery. The full set of draft key messages and feedback from the meeting is contained in **Appendix 3**.

Next steps

2.21 The SDP will be considered for endorsement by ESCC, West Sussex County Council and Brighton & Hove City Council in their capacity as joint statutory partners in the Sussex Health and Care Assembly and Integrated Care Strategy and partner members on the NHS Sussex ICB. Consideration of how well the SDP supports ESCC priorities, and commitment and ambition to deliver the best possible outcomes for residents through integrated care, will take place at the Leader and Lead Member for Strategic Management and Economic Development meeting on 20 June.

2.22 Following consideration on 27 June 2023 by the HWB, the final draft SDP will be submitted to NHS England by 30 June 2023, and the NHS Sussex ICB on the 5 July. The SDP will then be formally launched to coincide with the NHS 75th Anniversary celebrations and communications campaign. The new Sussex-wide Delivery Board arrangements will also be established in the same timeframe.

2.23 A communications and engagement plan is being finalised across system partners to support the publication of the SDP. This will involve the development of public-accessible versions of the plan to meet the needs of different audiences.

3. Conclusion and reasons for recommendations

3.1 The Sussex *Improving Lives Together* Strategy sets out a strategic statement of common purpose across Sussex, and the critical areas of focus of the Sussex Health and Care Assembly. As such it provides an overarching framework that will help the Health and Care Partnerships to work together in the three Places with the flexibility to improve health, reduce health inequalities and integrate care to suit the needs of their populations.

3.2 Good progress has been made with developing the Sussex Shared Delivery Plan with proactive engagement and support from system partners, to set out the arrangements for making this a reality over the next five-year timeframe. Part of this has involved managing the complexity of developing a cohesive single plan at a Sussex level, with significant progress made in developing a clear way forward which incorporates the NHS Operational Planning requirements and the delivery response to the Sussex Strategy and HWB Strategies.

3.3 Alignment of Senior Responsible Officers, including NHS Sussex Chief Officers, system Chief Executive Officers, Directors of Adult Social Care and Health, Public Health and Children's Services, has ensured collective commitment to the delivery framework. In totality the SDP it aims to present a clear improvement journey in the short, medium, and longer term.

3.4 Within this there are no changes to organisations' statutory roles and responsibilities for services and budgets. The SDP contains high level milestones and a roadmap covering the next 5 years. Were any detailed plans to be developed where the proposed changes to services would have significant impact on the East Sussex population, these would be subject to the normal process of engagement and formal consultation, including assessments of equality and health inequalities impacts and scrutiny by the Health Oversight and Scrutiny Committee, as appropriate and necessary to support accountability and decision-making by the relevant organisations.

3.5 Overall, the SDP supports delivery of shared priorities, and our shared commitment and ambition to deliver the best possible outcomes for our population, as well as achieving the best use of collective public funding in East Sussex, through integrated working across the County Council and NHS. It provides an overarching delivery framework that will help the Health and Care Partnerships to work together in East Sussex, West Sussex and Brighton & Hove, with the flexibility and added momentum necessary to support effective collaboration at Place level, so an ongoing detailed focus on local needs and priorities can be maintained to build on our existing progress.

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Appendices

Appendix 1 Draft Sussex Shared Delivery Plan

Appendix 2 East Sussex Health and Care Partnership and Programme Governance

Appendix 3 Draft key messages from the East Sussex Health and Care Partnership Board meeting

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Sussex Health&Care

Improving Lives Together

Ambition to Reality: Our Shared Delivery Plan

Contents

SECTION 1
Making our ambition a reality

Our ambition

Our ambition is to improve the lives of everyone living across Sussex now and in the future. We want local people to thrive to be the best they can be; to be healthier and feel supported; and have the best possible services available to them when and where they need them.

Our Integrated Care Strategy, *Improving Lives Together*, represents this ambition and sets out the agreed long-term improvement priorities we will be focusing on across health and care in Sussex that will bring the greatest benefits to local people and our workforce.

We know that currently people across Sussex are not always getting the support and care they need to live the healthiest life possible.

Our Case for Change outlines the issues we face as a health and care system and why health and care services are not always able to meet the needs of our population. This includes population factors such as our growing and ageing population that means more people need more care more often; the wider determinants of health, such as the social and economic environment our local communities are living within; and people's lifestyles. There is also the lasting impact the Covid-19 pandemic has had on both services and health, and the current cost of living crisis that is negatively affecting people's health and wellbeing.

We also have long-standing health inequalities, with communities and groups of people having worse health than other people because of who they are or where they live, particularly those who are most disadvantaged.

In addition, individuals, communities and our workforce have told us that people are not always getting what they need, when they need it due to difficulties accessing services, support and information, and the disjointed and confusing way the 'system' works.

A lot of work has already taken place across health and care over recent years to improve the support, care, and treatment available, and the timeliness of how people access services, and progress has been made that has brought benefits to local people. However, we recognise this has not always gone far enough in many areas and a lot of the issues we face can only be resolved through a more ambitious approach.

Improving Lives Together represents that ambition and has four aims:

- To improve health and health outcomes for local people and communities, especially those who are most disadvantaged.
- To tackle the health inequalities we have.
- To work better and smarter to get the most value out of the funding we have.
- To do more to support our communities to develop socially and economically.

We will do this through organisations working closer together and differently with and within our communities to support people through each stage of their lives. We want to:

- **Help local people start their lives well** by doing more to support and protect children, young people, and their families.
- **Help local people to live their lives well** by doing more to support people to stay well and to look after their own health and wellbeing.
- **Help local people to age well** by doing more to support older people to live independently for longer.
- **Help local people get the treatment, care, and support they need** when they do become ill by doing more to get them to the right service the first time.
- **Help our staff to do the best job they can** in the best possible working environment by doing more to support their own health and wellbeing and to promote opportunities which ensure people want to work in health and care services.

We want to achieve our ambition over the next five years and beyond and recognise that we will not be able to do everything at once, with some things taking longer than others to get up and running. So we need to be focused on what we can do and when. We also need to do it in a realistic way, using the money, workforce, and facilities we have available as a health and care system.

By working together across all system partners, and with local people and communities, we now have an opportunity to combine our collective energy, resource, and expertise to make our ambition a reality.

This Shared Delivery Plan sets out how we will do this over the next five years.

Our Shared Delivery Plan

Our Shared Delivery Plan brings together into one place the strategic, operational and partnership work that will take place across our system to improve health and care for our population over both the short and long term. It reflects and responds to national policy and guidance and aims to provide one single vehicle for delivery and focus for our system. It incorporates four delivery areas:

Delivery Area 1: Long-term improvement priorities [Section 2]

We will be building on work that is already taking place and taking new actions to progress the long-term improvement priorities that have been agreed across our health and care system. These are:

- A new joined-up community approach, through the development of Integrated Community Teams;
- Growing and developing our workforce;
- Improving our use of digital technology and information.

Delivery Area 2: Immediate improvement priorities [Section 3]

We recognise there are immediate improvements that need to be made to health and care services. Our health and care system is continually extremely challenged, due to high numbers of people needing support and care from services, and this means not everyone is always getting the right care, at the right time and in the right place for their needs. This has had an impact on some people's experience of services and their outcomes and has put intense pressure on our hard-working workforce.

A lot of work is taking place to give people better access to, and experience of, services and these are set out in our 2023-24 Operational Plan. From this plan, we are giving specific focus to four areas that need the most improvement:

- Increasing access to, and reducing variability in, Primary Care;
- Improving response times to 999 calls and reducing A&E waiting times;
- Reducing diagnostic and planned care waiting lists;
- Accelerating patient flow through, and discharge from, hospitals.

Delivery Area 3: Continuous Improvement Areas [Section 4]

To bring about the improvements we want to make to achieve our ambition, there are four key areas that need continuous focus and improvement:

- Addressing health inequalities that exist across our population to achieve greater equity in the experience, access, and outcomes of our population. This is a 'golden thread' running through the delivery of all the actions we are taking, and we also have a specific system-wide focus to help bring about short and long-term change.
- Addressing the mental health, learning disabilities and autism service improvements that we need to make across our system.

- Strong clinical leadership is crucial to enable us to make improvements to both health and care services and the health outcomes of local people.
- Getting the best use of the finances available. We will need to get the most out of the money we have available to invest in services and make sure we are working in the most effective and efficient way.

Delivery Area 4: Health and Wellbeing Strategies and Place-based Partnerships [Section 5]

Improving Lives Together is built on the Health and Wellbeing Strategies across our three 'places' of Brighton and Hove, East Sussex, and West Sussex. These set out the local priority areas of work taking place to best meet the needs of our diverse populations. Health and care organisations are working together to deliver these strategies, as well as the long-term, immediate, and continuous improvements that need to be made to achieve our ambition.

Figure 1: Overview of our Shared Delivery Plan

Alongside the four delivery areas, we have other areas of focus **[Section 6]** that will be part of, and cut across, all the work we do. This includes a focus on prevention, climate change commitments, supporting social and economic development, maternity and neonatal care, safeguarding and quality of services.

To support the delivery of our Shared Delivery Plan, our statutory organisations responsible for health and care will work together in a new way across four different levels – System level, NHS provider level, Place level, and Local Community Level **[Section 7].**

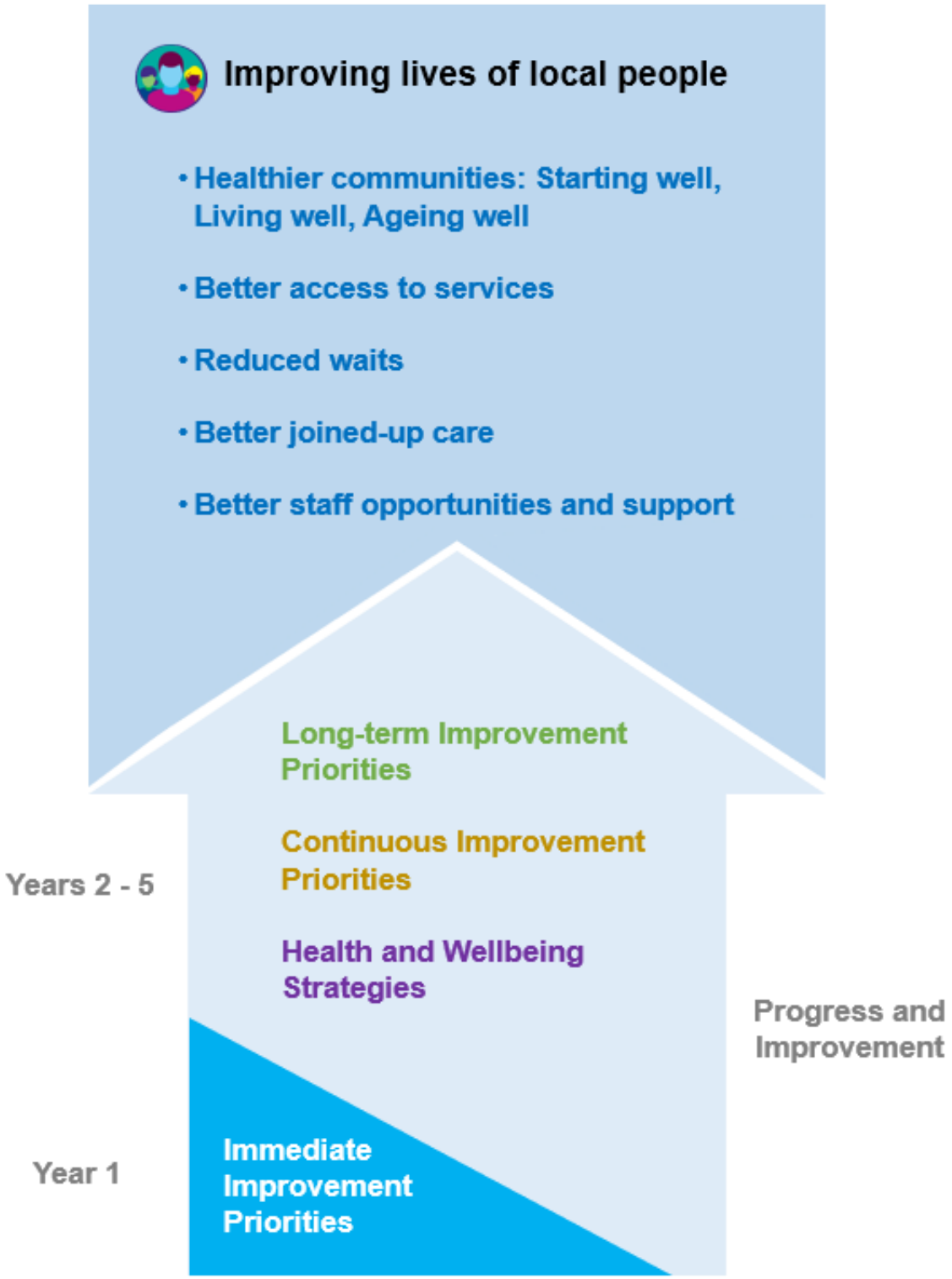
Each of the Long-term Improvement Priorities (Delivery Area 1), Immediate Improvement Priorities (Delivery Area 2) and Continuous Improvement Areas (Delivery Area 3) will be led by a Delivery Board, chaired by a system Chief Executive Officer, and they will have a workstream that will be resourced from across system partners. The work of these Boards and workstreams will be overseen by a System Oversight Board Chaired by the Chief Executive Officer of NHS Sussex. The Boards will address the needs of the whole population of Sussex. To ensure we deliver the focus we are committed to on the needs of children and young people, the system Children and Young People Board will contribute to and advise the work of each of the Delivery Boards to ensure that those needs are addressed.

How improvements will be made

The four delivery areas are not mutually exclusive; they support and interrelate with each other with the collective aim of making improvements over the next five years.

The actions taken across our Immediate Improvement Priorities (Delivery Area 2) aim to address issues that can be resolved in the short-term this year and make changes that give people better access to services and reduce waiting times. These will be supported and built on both this year and over the next five years across the Long-term Improvement Priorities (Delivery Area 1), the Continuous Improvement Areas (Delivery Area 3) and the actions in our Health and Wellbeing Strategies (Delivery Area 4) to address some of the deep-rooted and long-standing issues we face. Collectively, this will support longer-term improvement, change and transformation to the way services are delivered, the way organisations are organised and run and the health and wellbeing of local people.

Figure 2: Each of our Delivery Areas combine to make improvements for local people.



SECTION 2
Delivery Area 1: Long-term Improvement Priorities

Achieving our ambition is centred on three agreed long-term priorities – a new joined-up communities approach through Integrated Community Teams; growing and developing our workforce; and improving our use of digital technology and information.

Integrated Community Teams

Over the next five years we will be integrating health, social care, and health-related services across local communities in a way that best meets the needs of the local population, improves quality, and reduces inequalities. This will involve us working with local people to build on what works best already, and to create a multi-disciplinary workforce, tailored to the health and care needs of the community. We will do this by developing **Integrated Community Teams**, that are made up of professionals working together across different organisations with local communities, individuals, and their carers. This will involve integration across Primary Care, community, mental health, local authority partners, voluntary, community and social enterprise organisations and other local partners.

We will develop a **'core offer'** that each Integrated Community Team delivers to everyone, in addition to the individual support and services available to meet the specific needs of different communities. This new service model will be enabled by the delivery of our digital and workforce priorities, meaning our workforce has more time for direct care and to focus on population health management, prevention, and community engagement.

Our Integrated Community Teams will have specific focus on addressing health inequalities, taking preventative and proactive action, and working with local partners that support the wider determinants of health, including housing.

The initial work to progress this priority will build on what is already detailed in our respective Health and Wellbeing Strategies and test new ways of working through innovative programmes in each of our three places – Brighton and Hove, East Sussex, and West Sussex. The learning from these **'Integrated Community Frontrunners'** will be used to shape and inform roll-out of the Integrated Community Team model across our system.

Our Integrated Community Frontrunners

We have selected three programmes at each of our respective Places to be our Integrated Community Frontrunners. These will be tests of change for our new ways of working and our approach to clinical leadership, multi-disciplinary working, the way we use technology and data, and how we will work with local communities to better meet their needs.

Brighton and Hove frontrunner

Across Brighton and Hove, we are working to improve and join-up services to better support people with multiple compound needs and their carers. These are among the most marginalised and vulnerable members of society and face significant health inequalities. There is a 34-year life expectancy gap for people with multiple compound need compared to the general population and they are likely to be living in the most deprived area and specifically Central and East of Brighton.

The aim is for multidisciplinary teams to be working together to better co-ordinate services that are preventative, proactive, responsive, and empowering; enabling individuals to maximise control over their lives. Team members will pool their skills, professional experience, and knowledge to provide a rounded response to the people they are supporting.

The proof of concept started in November 2022 and is benefitting from an independently-led evaluation, monitoring, and learning framework that enables the model to be flexed through an action learning approach. By April 2024, it is planned there will be a reported improvement in the baseline performance metrics for the identified cohort.

East Sussex frontrunner

Hastings has some of the most deprived wards in the country and partners across health and care are currently working with community and voluntary organisations and local people to design and develop services and support in the future. The focus of the initial testing and development phase of the new model is to enhance and integrate our joined-up offer of health, care and wellbeing in communities and neighbourhoods. There are many existing projects and funding streams focussed on reducing the gap in health inequalities, including the gap in life expectancy and the needs of specific groups within this. The programme is intended to build on this to establish a framework for planning and delivering joined-up health, care, and wellbeing services to bring about the most benefit for the local population.

A project called ‘Universal Healthcare’ has been underway since June 2022 with a number of community engagement workshops taking place to understand the needs of local people and help shape how they can be better supported in the long-term.

Throughout year one, we will be co-designing a proof of concept and identify early ‘quick wins’ that can be implemented immediately. By April 2024, we will have an evaluation to support further delivery and improvement and a plan in place to roll-out the approach across other areas of East Sussex.

West Sussex frontrunner

Crawley is one of the most culturally diverse communities in West Sussex and has significant pockets of deprivation where people have poorer health outcomes than other areas of the county.

We have been running a programme of work since 2021 that is an innovative approach to tackling health inequalities and poor outcomes at a borough level. Its aim is to tailor health services and service models to meet the needs of the population with a focus on the most disadvantaged communities.

Phase One of the programme set out to understand what health service developments were required to address health inequalities and improve poor outcomes. We took a local approach to looking at the needs of the population and engaged with local people to understand what barriers they are facing, and what is a priority to help support their health and wellbeing. A range of service developments are being undertaken to ensure they can meet the needs of the local communities.

By April 2024, we will have developed key service business cases and plans and developed the estates strategic outline case.

The actions we are taking this year (2023-24) to progress Integrated Community Teams are:

What we will do	What we will achieve	When
We will define our Integrated Community Teams across Sussex.	We will have a clear footprint for Integrated Community Teams informed by our Joint Strategic Needs Assessments, Health and Wellbeing Strategies, and local population data and insights.	June 2023
We will have data and information in place to support our Integrated Community Teams.	We will be able to measure outcomes that have been agreed at a local level, using a consistent outcomes framework which can be used at a local level and be shared across the Sussex system.	December 2023

We will agree our core offer for communities.	We will define and agree the health and care needs, outcomes and 'core offer' that each Integrated Community Team will deliver to its population.	March 2024
We will test and refine our new ways of working through our three Integrated Community Frontrunners.	We will have learning documented to inform further roll-outs and our approach to clinical leadership, workforce and the use of technology and data.	March 2024

The actions we will take over years 2-5 to deliver Integrated Community Teams are:

What we will do	What we will achieve	When
We will undertake a stocktake and evaluation of year one.	We will understand what is important to local communities, supported by data, and a proposal for the new ways of working.	April 2024
We will further test and refine our new ways of working through our Integrated Community Frontrunners	We will have learning documented to inform further roll-outs and our approach to clinical leadership, workforce and the use of technology and data.	March 2025
Implement a continuous improvement and evaluation approach to improve and refine the way we deliver services within different local footprints.	We will have a continuous learning and improvement approach for Sussex Integrated Community Teams.	March 2027
Rolling out our Integrated Community Team model across Sussex in a series of agreed 'waves'.	We will have a sequential roll-out of Integrated Community teams across Sussex. We will see a steady improvement in patient access, more services delivered locally within different communities, improving patient experience, satisfaction, and outcomes.	March 2027

Difference this will make to local people and how it will be measured

Difference for local people	How it will be measured
Seamless delivery of Proactive Personalised Care.	Reduction in avoidable admissions and increased system capacity and resilience. Patient, carers and stakeholder feedback, qualitative and quantitative datasets, measuring patient journey through the lens of individual patients. Access, waiting time, experience, carer registration and outcome data. Service delivery and efficiency standards.
Tangible reduction in health inequalities, through a focus on prevention and addressing root causes of ill health.	Population Health Management - metrics to be defined to suit local need.
Increased provider resilience with significantly improved collaboration across different organisation boundaries within a patient pathway.	Staff survey results. Workforce evaluation and feedback. Reduced staff turnover. Patient satisfaction surveys.
Increased job satisfaction, career progression and resilience for our workforce.	Workforce evaluation and feedback. Reduced staff turnover.

Growing and developing our workforce

We want to support our staff and volunteers to do the best job they can by growing and developing our workforce. The number of people working in health and care has grown and we need to carry on increasing staff numbers but recruiting more is not the only answer. We need to also get the best out of the staff we already have. There are five objectives we want to achieve:

- Developing a 'one team' approach across health and care so they can work together and across different areas to help local people get the support and care they need.
- We want to support staff to develop new skills and expand the skills they have to allow them to work across different disciplines and areas. We also want to help staff to have more opportunities to progress in their careers.
- We want to create a more inclusive working environment that recognises diversity and has a workforce that better represents the population they care for.
- We want to encourage, and make it easier for, more young people, students, and people who have never considered a career in health and care, to work with us.
- We want to create a culture where people feel valued and supported to develop their skills and expertise. We want to take a 'lifelong learning' approach where people never stop developing their skills throughout their career.

The actions we are taking this year (2023-24) to better grow and develop our workforce are:

What we will do	What we will achieve	When
We will launch an innovative guaranteed employment scheme, in conjunction with Brighton University and Sussex Partnership NHS Foundation Trust (SPFT).	We will have supported SPFT to achieve an agreed reduction (subject to operational plan) in their registered mental health nurse vacancy rate.	June 2023
We will develop a People Plan with a delivery roadmap for Years 2 to 5. Our approach to ensuring an inclusive culture will be informed by our Workforce Race Equality Standard and Workforce Disability Equality Standard and gender pay gap data.	We will agree one approach to workforce across our system and how this will be implemented.	September 2023

We will agree the model for a single workforce support package across the system.	We will have an agreed single workforce support package in place.	December 2023
We will identify initial communities to test our one workforce approach.	We will begin to roll-out our one workforce approach.	March 2024

The actions we will take over years 2-5 to deliver our workforce aims are:

What we will do	What we will achieve	When
We will develop a digital training programme for Sussex.	Our staff will be better digitally trained.	March 2025
Based on the success of the SPFT and Guaranteed Employment model, we will adapt and adopt this process for an extended number of professions.	Guaranteed employment model will be adapted and adopted to create a pipeline of future workforce.	March 2025
We will review our Equality, Diversity, and Inclusion (EDI) offer across our system to strengthen our consistent approach in tackling inequalities, building on the success of our system Workforce Race Equality Strategy and Statement.	One approach to EDI support in place, taking account of individual organisations or professional context and needs.	March 2025
Build on the work to be undertaken in year one with our pilot Health Care Assistant collaborative bank and our South East regional collaborative with other systems.	Collaborative Bank process established.	March 2025
We will develop a workforce model for Integrated Community Teams.	Integrated Community Teams workforce model agreed.	March 2025
Start transition to new ways of working and provider form.	Colleagues can work in Integrated Community Teams with the same conditions, support inclusive of technology.	March 2026
Review transactional services.	Having a consistent approach to recruitment, payroll and Electronic Staff Record services.	April 2026 – March 2027

Difference this will make to local people and workforce and how it will be measured

Difference for our workforce and local people	How it will be measured
Improved working environment, opportunities, and development.	For all: Vacancy rates. Staff survey results. Retention rates. Workforce availability (inclusive of absence rates). EDI metrics such as WRES, WDES and Gender Pay. Temporary staffing usage Carer registrations among employees
Staff will connect better and form relationships with the community.	
Greater opportunities for people to work and have impact in the place they live, with flexible options.	
Better use of technology.	
Inclusive recruitment, with workforce that reflects its community.	
Opportunities for innovation and research.	

Improving the use of digital technology and information

We need to do much more to harness the potential for the use of digital technology and information. In doing so, we can improve access and join-up our services in a way that will fundamentally transform the experience for our local population and workforce.

We currently have too many disjointed systems, and data that is not shared and available at the point of need and we will be working with our communities and workforce to co-design and deliver long-term improvements.

For our Integrated Community Teams to succeed, we will need to ensure that information can be shared effectively across teams from multiple organisations, in a simple, timely way. We also need to simplify and democratise digital access to services for our population.

To do this, we will **Digitise**, **Connect**, and **Transform** our services.

- We need to **digitise** to put the right foundational technology, tools, leadership, and capability in place across our system, and in the hands of our population and workforce. We need to do this in a way that will improve and simplify access for all and reduce the variation we see that leads to inequality and digital exclusion impacting some people and communities more.

- We need to **connect** our population, partners and communities through digital and data services that enable them to play their part in tackling the challenges the system faces and in building trust in the data that informs care, population health management, research, and innovation.

- With the right digital and data foundations in place across our system, we need to then **transform** our services through co-design of more integrated ways of working within our Integrated Community Teams (via our Frontrunners), and across our system; use trusted data and insights to improve, innovate and explore new technologies.

People and communities will in future be able to choose high quality digital and data services, information, and technologies they have co-designed and can trust; information that supports them to live healthier lives; technologies to help manage their conditions and treatments; and services that communicate and plan with those involved in their treatment and care.

The actions we are taking this year (2023-24) to improve the use of digital technology and information are:

What we will do	What we will achieve	When
We will progress the work to digitise our services by evaluating our baseline position.	A system and provider digital maturity assessment will be completed and nationally benchmarked.	September 2023
We will agree a system-wide digital and data charter, setting out clear design principles and national benchmarking.	We will have 100% partners formally signed up to the charter.	September 2023
We will establish Digital Centres of Excellence in three providers to lead system improvements and innovation.	We will improve the quality and standard for infrastructure, data intelligence, and innovation across the system.	December 2023

We will map unwarranted variation of inequality of digital access within our population and create a plan to address it. We will establish a People's Panel for digital and data and embed our Digital Inclusion Framework.	We will establish where we have inequality of digital access within our population and better ensure a population-led design approach of digital and data services.	March 2024
We will agree a system-wide data, information, and insight strategy.	A strategy will be in place that will allow us to use data, information, and insight better.	March 2024
We will extend access and enrich services offered through the My Health and Care patient app (integrated with the NHS app).	We will have 65% of patients registered with the NHS App and 33% patients registered with My Health and Care.	March 2024
We will extend our digital service offering including virtual care technologies, care planning, self-referral, Primary Care accessibility and other capabilities	We will have an enhanced range of digital service provision and integration across the system.	March 2024

The actions we will take over years 2-5 to deliver improvements to the use of digital technology and information are:

What we will do	What we will achieve	When
Digitise: We will drive improvement across all partners of their digital maturity, cyber security and the commitments agreed in the digital and data charter. We will also work to embed strong digital inclusion practice and reduce unwarranted variation in access and equity of digital services.	Core Electronic Patient Records (EPRs) implemented in all providers. All Trusts will be consistently good in digital maturity across EPR and cyber security areas of digital maturity. Quantifiable progress in reducing impacts of digital exclusion and improving design of digital services.	April 2025 April 2025 April 2026

Connect: We will co-design, develop and deliver common digital and data platforms and products to enable our population, communities, workforce, researchers, and innovators to have access to the tools and insight they need to improve lives together. Our People's Panel will develop and publish the social rules under which we will operate.	Integrated Community Teams will connect and share data, including with patients, carers and VCSE partners, with 90% of care providers using shared care (Plexus) care record. NHS App and My Health and Care will be embedded as the "digital front door" in Sussex. Data platform for research and innovation will be fully developed. People's Panel will be publishing a Social Agreement for how we use Digital and Data tools to support their care.	April 2026
Transform: We will deliver our digital services through a sustainable model with provider Centres of Excellence; enabling co-design and innovation with our communities; developing our workforce, working in partnership with communities, academia, and industry.	Frontrunner Digital Innovation Lab will be developed. Digital and Data Science Academy will be launched to tackle long-term. recruitment, development, and retention issues. Provider Centres of Excellence will be developed in all partner providers across Sussex underpinned by sustainable environmental and financial model. Digital Innovation Labs will be operating across Sussex.	April 2025 April 2026 April 2026 April 2027

Difference this will make to local people and workforce and how it will be measured

Difference for local people and workforce	How will this be measured
Digitise: We will improve and simplify access to digital technology and services for all and reduce the variation we see that leads to inequality and digital exclusion impacting some people and communities more.	All providers will have consistently good digital maturity across Sussex and across What Good Looks Like domains. Key intervention programmes to tackle digital exclusion and inequity of service have been developed and are having measurable impact. Our population and workforce feel supported to use technology in the best way to suit them and their needs.
Connect: Our population, partners and communities will be connected through digital and data services that informs care, population health management, research, and innovation.	Digital health and care tools and support are established as an everyday service for significant cohorts of patients including those at risk of digital exclusion. People involved with the care and support of an individual (including the individual) share a common view of information and plans and can communicate across the Integrated Community Team.
Transform: Services will be transformed through co-design of more integrated ways of working within our Integrated Community Teams and across our system.	Citizen confidence and trust in digital and data services in Sussex will be improved with strong user experience measures across digital and data services. All providers have achieved core Minimum Digital Foundations safely, through clinically and patient-led implementations with sustainable infrastructure and resourcing in place to continuously improve services.

SECTION 3
Delivery Area 2: Immediate Improvement Priorities

Alongside the Long-term Improvement Priorities, there are immediate improvements that need to be made across our health and care services. We have developed and submitted an operational plan for 2023/24 which sets out the key actions that will be taken and how we will ensure best use of finances across our services.

We recognise that all service provision is vital for individuals and communities and work will continue to give people the best possible care and treatment they need in all areas. However, there is a need for us to make greater improvement across four key areas, to improve access to services and reduce the backlog in waiting lists that increased during the pandemic. Specifically, we need to:

- Increase access to, and reduce variability in, Primary Care;
- Improve response times to 999 calls and reducing A&E waiting times;
- Reduce diagnostic and planned care waiting lists;
- Accelerate patient flow through, and discharge from, hospitals.

The actions taken to make improvements in these areas will be carried out this year (2023-24) and will be reviewed, adapted, and built on in the years ahead, according to the effectiveness of the improvements and the needs of local people. The actions will also be supported by the Long-term Improvement Priorities that aim to address many of the issues faced across these areas over time.

Increasing access to, and reducing variability, in Primary Care

GP practices across Sussex work extremely hard to ensure their patients and carers get the timely support, treatment and care they need in the best possible way. In January 2023 alone, there were over 900,000 appointments offered by Sussex practices, which was 97,000 more than the previous month and over 120,000 more than the same time last year.

The growing number of people accessing GP services means it is increasingly becoming difficult for everyone to always get an appointment when the patient wants it. In addition, because each practice works differently, there is variation in how appointments are managed and accessed. This means some people trying to get an appointment can find some systems frustrating and the variation can exacerbate inequalities in access and outcomes.

While general patient satisfaction remains relatively high with GP services, it has declined over recent years and there are some areas where local people find it more difficult than others to access services.

Throughout this year, we will be focusing on increasing capacity across GP services, improving the quality of services and patient outcomes and supporting general practice services to be more sustainable. This includes maximising the benefits of virtual consultations, continuing to improve access to face-to-face appointments and reducing bureaucracy to free-up clinical time. At the end of the year, we expect patient satisfaction and experience to have improved, with patients having increased choice in access to same-day and two weekly appointments via a range of methods.

In addition to GP services, we are also focusing on improving access to NHS dentists. Over the last year we have heard significant feedback from local people and Healthwatch around issues with access to dentists across Sussex. This is something that is being experienced across the whole country. Responsibility for dentistry transferred from NHS England to NHS Sussex from April 2022 and we are working locally to make improvements where possible.

This work to improve access will also allow us to deliver continuity of care which is important for people managing multiple long-term conditions. This will be achieved by developing partnerships with the voluntary sector and expanding the roles within the general practice team to include social prescribers, pharmacists, physiotherapists, health and wellbeing coaches and others, to provide people seeking care and support the right contact first time. We will also focus on helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention, building on lessons learnt through the Covid-19 vaccination programme which is an example of how we can develop an Integrated Community Team response to vaccination.

The actions we are taking this year (2023-24) to improve Primary Care access and reduce variability are:

What we will do	What we will achieve	When
Increase people's ability to manage their own health through the NHS App, including booking an appointment.	Target, to be determined once baseline is known (July).	March 2024
Increased coverage of the cloud telephony system to improve service access.	95% of practices will be signed up.	September 2023
Increased practice staff able to provide direct patient care.	245 more staff recruited.	March 2024
Increase referrals to our Community Pharmacist.	We will increase referrals to 17,574.	March 2024

Increased levels of dental activity to improve access. This will include more opportunities for outreach into communities and those living in the most deprived quintiles and making every contact count by aligning the development of dental pathways across the public sector, including early years, health visiting and dental services.	Agree and establish an agreed approach for reporting on all relevant Public Health outcome indicators. Aligned NHS Sussex and Local Authority oral health promotion campaign and commissioning strategy. Improved units of dental activity (UDAs) to 95% of the contract.	September 2023 September 2023 March 2024

Difference this will make to local people and how it will be measured

Difference for local people	How will this be measured
It will be easier for patients to contact practices.	Patient satisfaction scores will improve by 5%.
Patients will be able to access more appointments.	There will be a 2% increase in appointments from the previous year.
Patients will be able to access an appointment within two weeks if they need it.	The number of people obtaining an appointment within two-weeks if they need it will increase by (3.1%) with an additional c.340,188 appointments delivered within two weeks, resulting in an increase from 81.9% during 22/23 to 85% during 23/24.
It will be easier to access a dental appointment.	The number of UDAs delivered compared to pre-pandemic levels (target 100%). UDAs delivered as a proportion of all UDAs contracted (target 95%). This relates to the ambition to improve delivery of contracted activity. Proportion of the Sussex population accessing NHS dental services (provisional target of 47%).

Improving response times to 999 calls and reducing A&E waiting times

Like many systems across the country, we have seen increasing numbers of people using urgent and emergency care services over recent years and this is putting significant strain on our workforce and has impacted on the timeliness for people accessing the care they need.

A lot of work has taken place to continuously look at ways the system can improve responsiveness, quality of care and patient satisfaction. This will be built on, expanded, and taken even further this year and we will be focusing on four key areas to make the biggest improvements:

- Improving and standardising care to give more of our population access to care which aligns with best practice.
- Expanding care outside hospital to ensure people's needs are met sooner and they do not have to end up going to acute hospitals for treatment and care.
- Expanding our use of virtual wards to allow more people to be cared for in their own homes when they would otherwise have gone into hospital for care.

The actions we are taking this year (2023-24) to improve response times to 999 calls and reduce A&E waiting times are:

What we will do	What we will achieve	When
We will undertake a full review of same-day emergency services in Sussex alongside an analysis of the different needs of our population.	We will have a clear understanding of the changes we need to make to ensure all local people have timely access to same-day emergency care.	June 2023.
We will increase capacity in our ambulance service, including the roll-out of mental health ambulances, 111 clinical advisory service, virtual wards, non-injured falls service, mental health same-day urgent care services, acute respiratory hubs, urgent community response services and Alternative to Admission Single Point of Access.	A greater number of people will receive rapid assessment and care for physical or mental health conditions in their own home or in the community and therefore avoid a hospital admission.	December 2023

We will support each of our acute hospital sites to undertake improvement work within their emergency departments, including a focus on rapidly streaming patients to the right service.	There will be improved flow of patients and their carers through emergency departments, enabling ambulances to be offloaded and minimising the time that patients spend in departments before being discharged or admitted.	December 2023
We will roll-out clear standardised pathways of care for individuals in Sussex who are at risk of a rapid deterioration in their health, including patients with respiratory illnesses or suffering from frailty.	Vulnerable individuals will spend more of their time in good health and receive rapid, early intervention through joined-up primary, community, and secondary care services when support is required.	March 2024

Difference this will make to local people and how it will be measured

Difference for local people	How will this be measured
More patients will experience shorter waits for treatment in A&E, Urgent Treatment Centres, and Minor Injury Units across Sussex.	We will achieve a minimum of 76% of patients and their carers attending A&E being seen within four hours.
Patients who call 999 with a time critical condition will receive a faster response from the ambulance service.	We will achieve the category 1 response time (90% of calls responded to within 15 minutes) and a better response rate of less than 30 minutes for category 2 (90% of calls responded to within 40 minutes).
More patients will receive medical care closer to home, with admission to an inpatient bed only occurring when absolutely necessary, enabling patients to be cared for in a familiar environment with their carers and the support of friends and family.	We will increase the number of virtual ward beds, reduce the number of ambulance conveyances to hospital (achieving better than the national average), expand 24/7 Mental Health Crisis resolution and home treatment services, increase the number of referrals to urgent community response services and deliver the two-hour urgent community response target of 75%.

Patients at high risk of hospital admission or who are frequent users of healthcare services will be provided with more proactive care and support to enable them to stay well.	We will see a reduction in the number of high intensity service users and a reduction in the number of admissions and length of stay for patients identified as high risk.
Patients waiting for or undergoing emergency treatment or awaiting admission will be cared for in appropriate clinical settings at all times and will either be admitted or discharged more quickly, spending less time in Emergency Departments.	No patients will be cared for in corridors within Emergency Departments while awaiting treatment or admission. The number of patients and their carers waiting in Emergency Departments for more than 12 hours will reduce to below 2%.

Reducing diagnostic and planned care waiting lists

There are currently large numbers of people waiting too long for diagnostic services and planned care, which can cause a deterioration in their condition, impact on their day-to-day lifestyle, and affect their general health and wellbeing. The lockdown restrictions that were put in place during the pandemic meant waiting times in these areas significantly increased and system partners have been working hard to reduce these as quickly as possible.

We will be maintaining and continuing this work this year and over the longer term will transform the way planned care and cancer services are delivered with the aim that no one waits over a year and we see movement towards achievement of the 18-week standard for elective care and 75% of cancers diagnosed at stage 1 or 2.

The actions we are taking this year (2023-24) to reduce diagnostic and planned care waiting lists are:

What we will do	What we will achieve	When
We will enhance patient and carers choice and access to treatment for key specialties including Ear, Nose and Throat and Trauma and Orthopaedic. We will establish clinically led workstreams to develop patient pathways that are productive and standardised across Sussex.	We will have agreed clinical pathways across all acute services for our key specialties to provide greater choice and access to patients and reduce waiting time variation across the system.	September 2023

To support patients and their carers who are referred on a cancer pathway, we will ensure referrals are made in-line with standardised referral protocols and local pathways are optimised, enabled by the Ardens Pro system which is in place across all practices in Sussex. We will continue to increase the number of patients referred with a Faecal Immunochemical Test (FIT) result at point of referral for a suspected colorectal cancer.	We will ensure patients are referred into the most appropriate service based on their referral and clinical information. With full compliance of colorectal referrals with a FIT test completed, we will reduce the number of colonoscopies required by up to 40%.	September 2023
We will make further use of our Community Diagnostics Centres (CDCs) across Sussex, providing greater access to patients who need a test to support a decision for the care they need.	We will prioritise direct access for primary care for computerised tomography (CT), ultrasound and Magnetic Resonance Imaging (MRI). We will have as a minimum six day working across our CDCs providing greater flexibility for patients.	December 2023
We will continue to realise productivity opportunities to make the best use of our resources, to provide greater access for patients.	We will increase our theatre utilisation rate to a minimum of 85% across all services. We will deliver at least 85% of surgery as a day case procedure. We will reduce the length of stay for key pathways such as hip and knee replacement surgery in-line with best practice rates.	March 2024
We will improve earlier access to hospital services with a focus on reducing the number of patients that do not attend (DNA) their appointment, continuing to provide virtual clinics to reduce the need for patients to attend the hospital, and provide greater flexibility to patients by increasing the number of 'Patient initiated Follow Up' (PIFU) appointments.	We will reduce our DNA rates across Sussex by at least 2% over the course of the year. We will reduce the number of follow up appointments generated by increasing our PIFU rate from 0.5% to 5% across Sussex. We will ensure at least 25% of outpatient activity is undertaken virtually.	March 2024

Difference this will make to local people and how it will be measured

Difference for local people	How will this be measured
We will continue to reduce our waiting times with a commitment to deliver a maximum wait for treatment for patients referred for elective care.	No patient will wait more than 65 weeks for their elective care treatment.
We will continue to reduce the number of patients waiting over 62 days for cancer treatment.	As a maximum, no more than 548 patients will be waiting over 62 days for cancer treatment by March 2024.
We will enhance access to diagnostics for patients across Sussex with our CDC capacity, improved diagnostics pathway, and capital investment in services.	We will ensure at least 75% of patients by March 2024 referred on a cancer pathway will be diagnosed within 28 days. We will continue to reduce our waiting times across 15 diagnostic modalities with no more than 10% of patients waiting more than six weeks.

Accelerating patient flow through, and discharge from, hospitals

There are currently too many patients being cared for in an inpatient hospital bed when there is no longer a health-related need for them to do so. This results in a lack of available beds across the system that can cause risks to both the patient, as they can deteriorate in hospital and be exposed to infection risks, and those waiting for inpatient care.

We have a good track record of system partnership working to improving discharges and we will be building on this and accelerating existing and new initiatives. Sussex is one of six national systems selected as Discharge Frontrunners, which involves health and social care partners locally working together, and with carers and wider partners, to rapidly find innovative solutions and new approaches which have the potential to make a substantial difference. Discharge Frontrunners use tried and tested improvement tools to find what works, how and why and will make recommendations for how their approaches can be adopted across the country. The objective of our programme is to develop, design and test new approaches and service models for discharges across all settings by focusing on integrated workforce models, deploying new technologies, developing shared business intelligence, and developing an economic and financial model to underpin this sustainably.

Our goal will be to bring together a comprehensive model of integrated hospital discharge to support good system patient flow with reduced lengths of hospital stay, admission avoidance, and better long-term outcomes for local people.

The actions we are taking this year (2023-24) to accelerate patient flow through, and discharge from, hospitals are:

What we will do	What we will achieve	When
We will undertake a comprehensive review of discharge pathways to identify, and put in place, improvement plans for the changes which need to be made to reduce delays to patients being discharged from inpatient and community services.	Health and care partners will have a more proactive approach to discharge planning, minimising delays at each part of the pathway (across pathways 0 to 3) and utilising virtual wards for early supported discharge, with a more seamless interface between health and care.	June 2023
We will evaluate and select a small number of digital innovations which will best support improvements in the discharge pathways, alongside the development of a shared data architecture to provide visibility of patient flow and capacity.	We will support more efficient use of our workforce, improved patient experience and seamless working between health and care colleagues.	September 2023 to select innovations; and March 2024 to roll it out.
We will develop an economic model for discharge in Sussex which enables us to make best use of available funding and supports the care market to expand in a sustainable way.	We will have a clear and affordable plan for the future to ensure we understand where best to invest available funds to grow discharge capacity which will meet the needs of our population.	December 2023
We will develop and mobilise a multi-agency workforce plan based on agreed discharge demand and capacity requirements.	We will develop our model for the health and care workforce to enable us to build the right capacity in home care or post-hospital bedded care to meet the needs of our population.	March 2024

Difference this will make to local people and how it will be measured

Difference for local people and workforce	How will this be measured
Patients and their carers will be involved in planning for their discharge from early in their inpatient stay and will be discharged without significant delay as soon as they are declared medically fit to do so into the most appropriate bed for their needs.	There will be a reduction in the number of patients who no longer meet the criteria to reside in hospital who are not discharged.
Patients will be admitted to an inpatient bed (acute, community or mental health) in the most appropriate department for their condition, without significant delay.	We will reduce bed occupancy to 92%.
Patients and their carers will be discharged earlier but receive ongoing clinical oversight where required using digital innovations such as remote monitoring.	There will be a reduction in hospital length of stay (quantified based on experience of exemplars).

SECTION 4
Delivery Area 3: Continuous Improvement Areas

To support the successful delivery of the actions set out across our Long-term and Immediate Improvement Priorities, and our Health and Wellbeing Strategies, there are four key areas that need continuous improvement:

- Addressing health inequalities
- Mental health, learning disabilities and autism
- Clinical leadership
- Getting the best use of the finances available

These areas are part of, and are critical success factors in, all the actions and improvements we are making and, therefore, need constant focus across everything we do.

Addressing health inequalities

There are currently avoidable and inequitable differences in health between different groups of people across Sussex. There are many reasons for this, including disability, employment, where someone lives, income, housing, education, their ethnicity, and their personal situation. We know these health inequalities are particularly seen among our most disadvantaged communities, with people living in deprived areas having worse health and outcomes.

Addressing health inequalities is a core aim of *Improving Lives Together* and is the driving purpose of developing Integrated Community Teams that better meet the needs of our diverse local communities. Health inequalities is a key priority of all our Health and Wellbeing Strategies and is a key element of all the workstreams of our Shared Delivery Plan and will be embedded within many of the actions outlined. This will be done with the following commitments:

- **Co-production** – we will work with those with lived experience to design and delivering change.
- **Interventions** – we will invest in prevention, personalised care, and other activities to drive reductions in heath inequalities.
- **Funding** – we will focus a greater amount of funding based on need.
- **Design of services** – we will undertake Equality and Health Inequalities Impact Assessments for all service changes.
- **Visibility** – we will ensure every decision we make considers the impact of proposals or decisions.

- **Outcomes and performance** – we will always consider the differences across geographical areas, population groups and other factors in how we set and monitor outcomes and performance.
- **Workforce** – we will actively recruit, develop, and support people from our diverse communities.
- **Net Zero and social value** – we will use our resources and assets to help address wider social, economic, or environmental factors.
- **Data quality and reporting** – we will drive work to both improve and increase the recording and reporting of data by key characteristics.

In addition to, and to support, the work across our workstreams and the Health and Wellbeing Strategies, we are taking the following actions to address health inequalities.

The actions we are taking this year (2023-24) to make progress to address health inequalities are:

What we will do	What we will achieve	When
Working with children and young people (CYP), partners, and young carers to develop a defined work programme around the CYP Core20PLUS5 similar to the adults' Core20PLUS5. This will include: • Address over-reliance on asthma reliever medication and decrease in number of asthma attacks. • Increase access to real time continuous glucose monitoring, and insulin pumps, in the most deprived areas, and from ethnic minority backgrounds. • Increase access to epilepsy specialist nurses within the first year for those with learning disabilities or autism • Address backlog for tooth extractions for under-10's. Improve Mental Health access rates for 0–17-year-olds from ethnic minorities and children in greatest areas of deprivation.	Develop CYP Core20PLUS5 baseline and improvement trajectory across each of the five clinical areas.	December 2023

Improve position against 2022-23 baseline on hypertension identification and treatment and increase lipid lowering therapy (LLT) prescription.	Hypertension: We will improve from the September 2022 position performance of 57% to 77%. Lipid lowering: We will increase from September 2022 position of 53% to 60%.	March 2024
Continue the roll-out of the NHS funded offer of universal smoking tobacco treatment services, across inpatient, maternity, and mental health services and ensure investment at scale and sustainability beyond 2023/24.	Increase proportion of adult inpatient settings offering tobacco dependence services from 0% baseline to 20%. Increase proportion of maternity settings offering tobacco dependence services from 50% to 80%.	March 2024
Address inequalities and improve outcomes in priority clinical pathways for those in deprived geographical areas and with vulnerable or protected characteristics. This includes: • Reducing waiting times, DNA, and cancellation rates in our most deprived areas and those with protected characteristics. • Establishing an inclusion health programme, identify gaps in provision and develop associated commissioning plans. • Improve recording of ethnicity recording across all providers. • Commissioned baselining of LGBTQ+ and Learning Disability data recording.	Reduced waiting times, DNA, and cancellation rates for those in deprived geographical areas and protected characteristic groups by 5%. Commissioned dedicated inclusion health network - 60% of providers signed up. Ethnicity recording moved from 65% to 90% data completeness. Data recording baseline achieved for LGBTQ+ and Learning Disability.	March 2024

The actions we will take over years 2-5 to further reduce health inequalities are:

What we will do	What we will achieve	When
Improve position against 2022/23 baseline on hypertension identification and treatment, and lipid lowering therapy prescription.	Hypertension: We will continue to improve performance to 80%. Lipid lowering: We will continue to improve performance to 70%.	March 2028
Continued support for the roll-out of the NHS funded offer of universal smoking tobacco treatment services, across inpatient, maternity, and mental health services and ensure investment at scale and sustainability beyond 2023/24.	Increase proportion of adult inpatient settings offering tobacco dependence services from 20% to 50% year two and to 80% by year five. Increase proportion of maternity settings offering tobacco dependence services from 80% to 100% by year five.	March 2028
Continue to address inequalities and improve outcomes in priority clinical pathways for those in deprived geographical areas and with vulnerable/protected characteristics.	Build on reducing waiting times, DNA, and cancellation rates in our most deprived areas and those with protected characteristics by reducing further on year one by 5% in years two and three. Dedicated inclusion health network established with 90% of providers signed up by year five. Identified gaps in services commissioned during years two to five. Ethnicity data completeness moving from 90% to 100% data completeness. Data completeness of 50% by year two and 75% by year five for LGBTQ+ and Learning Disability.	March 2028
Dedicated Children and Young Persons (CYP) programme for Core20PLUS5.	5% increase on year one baseline figures by year two and 20% increase on baseline year one figures by year five.	March 2028

Difference this will make to local people and how it will be measured

Difference for local people and workforce	How will this be measured
Improved and equitable access to health care for the population, particularly those in our deprived areas and those with protected characteristics.	Improvement in waiting times and access to treatment times for those from our most deprived areas and with protected characteristics.
Reduced inequalities, and variation in population outcomes.	Reduction in the number of avoidable stroke and cardiac events for adults. Improved access rates to mental health services from areas of deprivation, CYP, males and certain ethnic groups. Improved healthy life expectancy and life expectancy for people with severe mental illness and learning disabilities. Fewer CYP asthma events requiring emergency admissions, improved access to specialist nurse for those with epilepsy, learning disabilities and autism and fewer dental extractions for 0-10 years.
Reduced inequalities in delivery of services, service developments, commissioning, and employment.	Reduction in gaps for health inclusion groups in community service provision, which will reduce requirements for emergency and urgent care and fewer GP appointments.
Inclusive digital pathways.	Focused and reasonable adjustments will be applied to digital pathways to support population groups at risk of digital exclusion.

Mental Health, Learning Disabilities and Autism

Supporting people with mental health, learning disabilities and autism is a key priority across system partners. Although we are working across these areas in one workstream, they are separate areas of focus and will require differing approaches and actions.

Our aim is to ensure those who are suffering from emotional distress and mental ill health get the support, care, and treatment they need as quickly as possible and can live fulfilled lives within their communities. A lot of work has taken place to improve mental health services, including establishing the specialist perinatal mental health community service, increased physical health checks for those with serious mental illness, and recruitment of additional clinical staff in the eating disorder service. This has been done through consistent delivery of the Mental Health Investment Standard (MHIS) and this will be achieved again in 2023-24 at a level of 7.1%.

Despite funding and staffing levels increasing, the need for mental health services has grown exponentially in recent years, with the pandemic contributing to a rapid rise in emotional distress, depression and anxiety, and many individuals are still facing lengthy waits for assessment and treatment.

We are taking action in response to this growing need through our operational plan this year (2023-24) and over the longer term:

- We will improve care for those facing mental health crisis through rapid access to crisis services, such as NHS 111 links to the crisis line, Crisis Houses, Safe Havens, and specialist teams that will support the emergency services where an individual with mental health needs is being detained.
- We will continue to improve access to support for children and young people, access to talking therapy services for adults and perinatal services.
- We will eliminate out of area placements to provide care closer to home.
- We will work to increase dementia diagnosis through schemes such as the locally commissioned services in Primary Care.
- We will continue to deliver and work towards meeting the commitments detailed within the NHS Mental Health Plan 2019/20-2023/24 across the range of services.

These key commitments sit within the context of a comprehensive programme of transformation focused on population health and wellbeing and addressing health inequalities.

Alongside our focus on mental health, we are working to improve the care and outcomes for those with learning disabilities and autism. This includes:

- Working to ensure those with learning disabilities receive an annual health check and action plan.
- Reducing reliance on inpatient care, and improving the quality of inpatient care, for those with a learning disability and who are autistic through providing services in the community.

- Working with the NHS England South East Regional team on the regional delivery plan which includes special educational needs and disabilities (SEND) to improve outcomes.

The actions we are taking this year (2023-24) to make progress for those with mental health issues, learning disabilities, and autism are:

What we will do	What we will achieve	When
We will ensure care is offered close to home.	We will eliminate out of area placements.	From June 2023
Increase the numbers of adults accessing talking therapies (formerly known as IAPT services).	We will increase access by 5%.	March 2024
Increase the number of adults and older people supported by the community mental health team.	We will increase support by 5%.	March 2024
We will develop a locally commissioned service to improve our dementia diagnosis rate.	We will increase the dementia diagnosis rate by 0.3% as a minimum from 22/23.	March 2024
We will improve access to perinatal mental health services.	We will increase access by 1%.	March 2024
We will commence a Child and Adolescent Mental Health Service (CAMHS)/acute pathway programme involving all partners.	We will agree and develop a system approach to children and young people requiring an acute response from CAMHS services as part of the wider support network.	March 2024
We will maintain a strong commitment to reducing reliance on inpatient care for both adults and children with a learning disability and/or who are autistic, consistent with the ambition set out in the NHS Long Term Plan, and to develop community services to	30 adult and 15 CYP inpatients per million population,	March 2024

support admission avoidance and timely discharge.		
We will increase the number of people on the Learning Disability Register who have received an annual health check and action plan.	We will increase the uptake of annual health checks for those on the Learning Disability Register to 75%.	March 2024

The actions we will take over years 2-5 to further improve the experience of those with mental health issues, learning disabilities and autism are:

What we will do	What we will achieve	When
We will develop a strategy that strengthens commissioning aligned to a collaborative delivery of outcomes; enabling increased lead provider arrangements that deliver whole pathway approaches.	Reduced pathway fragmentation, increased provider sustainability and productivity and improved patient and carer outcomes and experience.	March 2025
Fully implement the community transformation plan within Sussex with an agreed and defined model in each place, including a functional single point of access and developed specialist pathways.	A consistent approach to supporting all people that present with mental health problems at primary care level and more cohesive service offer within Primary Care and secondary care mental health services.	March 2025
Develop closer linking of mental and physical health planning and delivery through the Integrated Community Teams approach.	Increased integrated community-based access to support, reducing reliance on more specialist care and delivering improved health outcomes for local people.	March 2025
We will review the existing successful plans for reducing out of area placements and embed practice as business as usual with continuous review and evaluation.	Continuation of the recent reduction of out of area placements offering better experiences for those that require admission and maintain a 0% tolerance.	March 2025
Agree and formalise a dementia model and strategy for each place that is consistent and meets national best practice with the	The memory services will offer a clearer and timelier assessment and diagnostic service that will support the existing pre and post diagnostic support for people with dementia. It	March 2025

implementation of locally commissioned Primary Care services to support diagnostic rates.	will also support wider system strategies.	
Develop and fully embed physical health checks for people with severe mental illness outreach and health improvement support in Primary Care as part of Emotional Wellbeing Service and mental health transformation objectives.	We will maintain completed annual comprehensive physical health checks to 75% of GP severe mental illness (SMI) registers.	March 2025
Implement the recommendations of the CAMHS review project.	We will improve timeliness of flow through CAMHS services with a consistent offer for children and young people. It will offer improved patient experience and achieve better outcomes for individuals and improve the offer and links to support education and social care processes.	March 2026
We will review the profile of mental health investment to ensure a balanced approach across children and adult services that reflects population demographic and need.	An enhanced focus on early intervention and wellbeing support that reduces reliance on specialist and bed-based services and addresses inequalities in access and provision.	March 2026
We will support the NHS regional plan to offer a cohesive service within our area and engage within the planning process.	This will allow a wider range of interventions across the region to be provided more consistently and will allow us to maximise our resources better on a larger geographical footprint.	October 2026

Difference this will make to local people and how it will be measured

Difference for local people and workforce	How will this be measured
We will undertake a system-wide participation and co-production strategy review, with local authority, experts by experience and VCSE partners, that will be embedded within all work programmes consistently and at all levels of development, review, and evaluation throughout mental health services.	Development of the participation matrix has been agreed with milestones being reported monthly to the Performance and Assurance Group and to the system multi-stakeholder mental health board.
We will have a mental health workforce that is consistent and suitably trained who feel supported and offered opportunities to develop best practice.	Annual staff surveys with a robust audit of issues raised, with associated recommendations and actions that may impact on this commitment led by chief officers.
We will have health and care services working as one team to provide a holistic offer of support to people with mental health and learning disabilities in the community in which they live.	Increase in the uptake of annual physical health checks. Increase in access to preventative and timely access to treatment services, same level as those without mental health or learning disabilities.

Clinical Leadership

There is clear evidence that strong clinical and care professional leadership is associated with higher productivity, better organisational performance, and improved health outcomes for local people. The delivery of our ambition will only be successful with strong clinical leadership, and it is recognised that this is something in Sussex that needs to be developed and strengthened at every level within the system.

We want to create a culture that systematically embraces shared learning, based on outcome data, to support clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities. The aim is for patients to have a better quality of joined-up care, better clinical outcomes, and better experience. This will require close working across system partners, including social care, housing, education, and other Local Authority colleagues, as well as the NHS.

The actions we are taking this year (2023-24) to make progress in clinical leadership are:

What we will do	What we will achieve	When
We will formally appoint a clinical leader for each of the three Integrated Community Team Frontrunner programmes.	The development of Integrated Community Teams will be clinically led.	June 2023
Establish multi-professional Clinical Reference Groups (CRG) for each of our Shared Delivery Plan priority areas.	Governance structure confirmed and implemented for the Clinical Reference Groups.	June 2023
Set out benchmarks for improvements in clinical outcomes.	Agree reduction plan in unwarranted variation.	September 2023
Agree an organisational development approach to quality improvement and use of data.	Agree Quality Improvement training and data baseline. Progress training plan in identified Clinical Leadership Group.	September 2023
Put in place a multi-professional Leadership Academy to develop our clinical leaders across the system.	100 leaders will have undertaken the programme.	March 2024

The actions we will take over years 2-5 to further develop, improve, and progress clinical leadership are:

What we will do	What we will achieve	When
Agreement on clinical support for delivery workstreams.	Review function of Clinical Reference Group support for year one delivery priorities for effectiveness.	March 2025
Review the 100 leaders who have undertaken the Clinical Leadership Academy programmes and work on lessons learned and ways to improve.	Ensure that clinical leaders selected for each of the Integrated Community Teams areas are well trained and supported for leadership.	March 2025

Embed delivery of clinical outcomes as related to each Delivery Board.	Improve the clinical outcomes of greatest importance for the population of Sussex to deliver measurable impacts.	March 2027
Develop the model of clinical delivery within our ICTs year-on-year and build on the use of digital and data within our pathways.	Clinicians are able to use the opportunities of digital, data and technology.	March 2027
Clinical leadership to ensure clinical interventions and transformation are being delivered using the highest quality evidence, though multi-professional teams using continuous improvement cycles.	Review of outcomes of Integrated Community Teams across Sussex to ensure impact of clinical leadership for delivering high quality care and evidence by using agreed metrics.	March 2028
Clinician leaders demonstrating their proficiency in using digital, data and technology as a means of improving the clinical interventions.	Clinical leaders will be using clinical interventions and research data to demonstrate the effectiveness of interventions in clinical pathways.	March 2028
Clinical ownership of population outcomes.	Clinical leaders will be able to demonstrate improvements in agreed clinical outcomes in the pathway of care for the community.	March 2028

Difference this will make to local people and workforce and how it will be measured

Difference for local people and workforce	How will this be measured
There will be integrated working within Integrated Community Teams and networking across the system partners, with a greater focus on preventing ill health and on evidence-based impacts of personalised care.	Public satisfaction with services survey.
Sussex will be an attractive place to work for clinicians, attracting and retaining talent who are able to see they are making a positive difference to local people.	Staff survey on satisfaction and engagement for Trusts.

Getting the best from the finances available

Financial sustainability is integral to delivering our ambition as it is a key part of enabling our health and care system to drive improvements to services for local people. We must live within the finances we have available and, to do so, it is crucial that all organisations across our system manages resources effectively, ensuring value for money from every pound spent.

Currently, the NHS across the Sussex system is challenged financially and has a recurrent deficit, which means it is spending more than its allocation. We must therefore work collaboratively across the system to make efficiencies in how we work to get the most out of the money we have available. It also means we must be targeted in our investments, to ensure we are getting most value for local people. In addition, NHS Sussex is required to make running cost reductions of 20% from 2024/25, with a further 10% reduction from 2025/26.

The Sussex system receives a capital allocation, used to upgrade estates and equipment, and must prioritise all the capital requirements to make sure the funding available is spent in the most effective way. In addition, we receive national capital funding for specific programmes and projects. Over the next five years we will invest in some significant developments which will radically improve patient experience and our productivity. Examples include a new Emergency Department in Brighton, a programme which will eradicate mental health dormitory accommodation, the development of community diagnostic centres and new facilities to deliver elective activity.

A key area of focus for us in improving our finances is productivity, which is the amount of activity we do compared to what it costs. Currently, we are not getting the best use of the money we spend in some areas, such as in our acute hospitals, where current productivity is significantly lower than before the pandemic. To improve our productivity, we have agreed a set of principles and actions across four areas, overseen by a system Productivity Steering Group. These aim to ensure the system is maximising value for money from use of its public funding, expertise, technology, and estates to deliver services. These are:

- System-led workstreams: To develop a joined-up Sussex approach and reduce variations across providers across areas such as workforce, procurement, and discharge.

- Provider-centric workstreams: To share best practice across providers and identify system opportunities across areas such as theatre productivity, outpatient opportunities and A&E.

- Integrated approach: Focusing on productivity opportunities that may impact on both primary and secondary care and potentially areas that impact multiple services/ pathways, including medicine optimisation.

- Non-pay saving opportunities: To explore medium-term opportunities in areas like estate optimisation and corporate service.

The actions we are taking this year (2023-24) to get the best from the finances available are:

What we will do	What we will achieve	When
We will create a comprehensive and resourced system productivity plan, with individual workstream targets and milestones and measurable cost reductions demonstrated.	We will have a plan for improving system productivity.	September 2023
We will develop a clinically-led process for optimising some of our clinical models or services, to reduce cost.	Three services or models will be taken forward led by clinicians.	December 2023
We will implement initiatives to improve productivity.	We will see productivity improvement compared to 2019/20 of 10 percentage points, to 7% below 2019/20 for acute Trusts.	March 2024
We will agree a methodology for assessing productivity output for community, mental health, and Primary Care services.	We will have key performance indicators and methodology for productivity across services outside of acute hospitals.	March 2024
We will deliver our 2023/24 system financial plan.	We will meet our financial budget at the end of the year.	March 2024

The actions we will take over years 2-5 to continue to get the best from the finances available are:

What we will do	What we will achieve	When
Model the medium-term financial position of the system including the improvements we would expect as a result of the productivity improvements.	A medium-term financial plan owned by the system.	March 2025

Build a longer-term plan for productivity improvements.	A rolling programme of productivity and efficiency improvements.	March 2025
Review and consider national and international financial frameworks which would support delivery of the Shared Delivery Plan.	A revised financial framework which supports the strategy.	March 2026
Make clinical leadership the natural driver of the productivity improvement programme.	Build enduring clinical leadership into the productivity programme, linking with the Clinical Leadership workstream.	March 2028
Ensure Sussex can live within its financial allocation each year, giving us the freedom to implement our Shared Delivery Plan.	Deliver the annual financial plans.	March 2028
Optimise our capital allocation through prioritising strategic capital requirements.	A prioritised capital plan for 2025/26 onwards (2023/24 and 2024/25 already done).	March 2028
Model and plan the financial impact of all the elements of the five-year plan.	A detailed investment and efficiency plan showing where cost and income will change.	March 2025

Difference this will make to local people and workforce and how it will be measured

Difference for local people and workforce	How will this be measured
Living within our financial allocation will allow for greater investment in new services and innovation to support and accelerate improvements for local people.	Financial positions across system partners at the end of each financial year.
Greater productivity and efficiency will help people to be seen and treated quicker.	Productivity improvement across the system.
Significant major capital developments which will provide improved facilities and better patient experience.	Capital programmes delivered to time and budget.

SECTION 5

Delivery Area 4: Health and Wellbeing Strategies and developing Place-based Partnerships

Improving Lives Together supports and builds on the three Health and Wellbeing Strategies in place across Sussex. The Health and Wellbeing Boards in Brighton and Hove, East Sussex and West Sussex have a statutory role to bring together representation from local government; local NHS organisations; Healthwatch; voluntary, community, social enterprise organisations; and other key public services to assess needs and agree plans, focussed on improving health, care and the overall social and economic wellbeing of their populations.

The Health and Wellbeing Strategies use local evidence, data, and insight to set out the priorities for improving health and wellbeing of their populations, responding to the distinct issues and challenges in these places.

Alongside the delivery of the Health and Wellbeing Strategies, one of the key priorities of *Improving Lives Together* is 'maximising the power of partnerships' and during year one we will be strengthening how partners can work together across our populations in Brighton and Hove, East Sussex, and West Sussex, focussing on the distinct needs and challenges in our local areas. We call this working at 'place', and it is where the local NHS, local government and a wide range of local partners come together to shape and transform health and care and make the most of the collective resources available. We will do this by working in our three Health and Care Partnerships, whose work is overseen by the Health and Wellbeing Boards. Further details of how these partnerships fit into the way of working across our system is in **Section 7**.

The ways of working and priorities across each of our places are set out below.

Brighton and Hove

Our 2019-30 Health and Wellbeing Strategy focuses on improving health and wellbeing outcomes for the city and across the key life stages of local residents - starting well, living well, ageing well and dying well. Our ambition for Brighton and Hove in 2030 is that:

- People will live more years in good health (reversing the current falling trend in healthy life expectancy).
- The gap in healthy life expectancy between people living in the most and least disadvantaged areas of the city will be reduced.

Eight principles guide the delivery of our strategy with a focus on health being everyone's business; supporting communities to be more resilient; reducing health inequalities; and making sure that health and care services will provide high quality care, feel more joined-up and will be delivered in the most appropriate place.

The establishment of the Health and Care Partnership Executive Board in January 2020 enables us to build upon the work already started and is now becoming formalised. The firm foundations of the Board enable us to develop and mature service design, delivery, and governance over the coming years.

Our ambitions for improving lives at place

The ambitions set out in our Health and Wellbeing Strategy are:

- Brighton and Hove will be a place which helps people to be healthy.
- The health and wellbeing of young people will be improved. We will have a focus on early years encouraging immunisation; we will address risks to good emotional health and wellbeing; and provide high quality joined-up services which consider the whole family.
- The health and wellbeing of working age adults will be improved. Information, advice, and support will be provided to help people to eat well, move more, drink less and stop smoking to reduce their risk of developing long-term health conditions. There will be easier access to mental health and wellbeing services; sexual health will be improved; and people with disabilities and long-term conditions, and the long-term unemployed, will be supported into work.
- Brighton and Hove will be a place where people can age well. People will be supported to reduce loneliness and social isolation and to reduce their risk of falls and more people will be helped to live independently by services that connect them with their communities.
- The experiences of those at the end of their life, whatever their age, will be improved. We will improve health and wellbeing at the end of life and help communities to develop their own approaches to death, dying, loss and caring. More people will die at home or in the place that they choose and support for families, carers and the bereaved will be enhanced.

How we will deliver our ambition

The Health and Wellbeing Strategy identifies five priority areas for Brighton and Hove:

- **Children and Young People**: We will improve and expand access and existing support to children and young people and their families for mental health, emotional wellbeing, autism, Attention Deficit Hyperactivity Disorder (ADHD), and other neurodevelopmental conditions. We will improve early diagnosis and outcomes for children and young people and increase the identification of, and support for, young carers.
- **Mental Health:** We will implement the key recommendations of our 2022 mental health Joint Strategic Needs Assessment, expanding our support for people with mental health needs and further developing integrated community mental health services, connecting mental health services with community

assets. We will do this at local community level and develop integrated systems and increase the provision of supported accommodation and support for people with mental health needs, co-occurring disease, and substance misuse services.

- **Multiple Long-term conditions:** We will improve services to people with long-term conditions to deliver personalised care, tailored to individual needs, strengths, and capabilities. We will aim to better understand the interaction of mental and physical health conditions as a factor to improve outcomes and we will proactively identify and/or support and meet the needs of those at risk of or living with long-term conditions.
- **Cancer:** We will complete the recovery of cancer services affected by the pandemic, improve performance against cancer waiting times standards and deliver the ambitions of the NHS Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas and under-served communities where rates of early diagnosis and screening uptake are lower.
- **Multiple Compound Needs**: We will improve and join-up services to better support people with multiple compound needs by delivering an integrated service model, co-produced for and by people with lived experience. We will do this through our Integrated Community Frontrunner programme.

The actions we are taking this year (2023-24) to deliver our Brighton and Hove Placed-based priorities are:

What we will do	What we will achieve	When
Integrated Community Teams frontrunner: Through our multi-disciplinary team pilot we will trial and develop a new integrated model of care and support for people with multiple compound needs and their carers. This will be supported by a clear set of programme objectives, a compact agreement between system partners and an independent evaluation of our pilot project.	We will develop a clear set of programme objectives that supports our aim of increasing life expectancy for people with multiple compound needs. We will establish a compact agreement, across system partners that supports a new integrated model of care and support. We will get an independent evaluation of our pilot project to inform future service design and commissioning.	March 2024
Health inequalities: We will build on the work with Public Health to reduce the spread of blood borne viruses. We will deliver the aims of our current commissioned health inequalities	We will build on HIV ED opt-out testing and commence the opt-out blood borne testing.	March 2024

services working with the local population, VCSE and our providers to responds to known areas of health inequalities.	We will improve experience, access, and outcomes for the most disadvantaged communities in Brighton and Hove.	
Children and young people (CYP): We will implement year one emotional wellbeing action plan priorities for the Foundations for Our Future Place-based Plan. This will include a new emotional wellbeing pathway for CYP and embed training at point of induction for social workers and annual refreshers thereafter.	We will improve the support and interventions for children and young people who are neurodiverse and for children and young people with mental health needs and their carers.	March 2024
Mental health: We will implement the recommendations of the 2022 Mental Health and Wellbeing JSNA ensuring that progress is made across all seven delivery areas - extend and expand the range of emotional wellbeing services to Primary Care Networks, physical health checks for people with severe mental illness, develop suicide and self-harm prevention action plan.	Increase access to community mental health services. Reduce demand on acute and crisis care. Increase the number of people on severe mental illness registers.	March 2024
Cancer: We will build on the work with Public Health, the local population, VCSE and our providers to help to detect cancer at an early stage through promoting uptake of screening programmes, including expanding the targeted lung health checks programme, Faecal Immunochemical Test (FIT) testing and continuing the fibro scanning outreach service (to check for liver inflammation). The programme will ensure it responds to known areas of health inequalities.	Increased screening rates including in areas of deprivation and communities, including BAME communities, people experiencing homelessness, Trans people, and people with learning disabilities.	March 2024
Multiple long-term conditions: We will develop our cardiovascular disease reduction priorities in Brighton and Hove including hypertension case finding and treatment, and the restoration of the NHS health checks programme with health inequalities lens.	The cardiovascular disease reduction action plan will be developed and monitored at the Brighton and Hove Community Oversight Group.	March 2024

Hospital discharge: We will develop our integrated model, implement the 2023-24 hospital discharge transformation plan, and deliver the improvements aligned with the discharge frontrunner programme. Our place-based discharge transformation work will happen to ensure efficiency within current processes.	This will enable us to ensure people who no longer need acute inpatient care can go home or to a community setting to continue recovery with appropriate support for any unpaid family/friend carers who help that patient.	March 2024

The actions we will take over years 2-5 to continue to deliver our Brighton and Hove Place-based priorities are:

What we will do	What we will achieve	When
Integrated Community Teams frontrunner: We will evaluate the impact and results of our multi-disciplinary team pilot project, including the independent evaluation report. This will inform our longer-term redesign of services for people with multiple compound needs.	We will develop a long-term integrated model of service, where partner organisations from across the public and community sector will work together as a multidisciplinary team. Service-users and their carers will experience a joined-up service that best meets their multiple health and social care needs.	March 2028
Health inequalities: We will further develop our prevention programmes, in-line with our Health and Wellbeing Strategy priorities, with an increased focus on reducing health inequalities in identified populations and locations across the city.	We will reduce barriers, increase service use, and improve health outcomes for the most disadvantaged communities in the city.	March 2028
Children and young people: We will implement Year 2-5 action plan priorities for Foundations for Our Future Place-based Plan.	We will improve the support and interventions for children and young people who are neurodiverse and for children and young people with mental health needs.	March 2028

Mental health: We will transform the community mental health system, improving access though provision of holistic care, shifting investment to increasingly focus on CYP as well as prevention. Improve access to stable and secure housing and accommodation-related support for people with serious long term mental health conditions.	We will improve access to community mental health services – both numbers of people accessing and reduction in waiting lists. We will improve access to CYP mental health services - both numbers of people accessing and reduction in waiting lists. We will increase the number of people on the severe mental illness register. We will deliver a reduction in use of avoidable crisis and acute care.	March 2028
Cancer: In-line with the Brighton and Hove wellbeing strategy, we will expand cancer diagnostic and treatment service capacity, enabling earlier diagnosis of cancers through use of community diagnostic centres.	We will achieve the 28 day faster diagnosis standard (75%). We will increase the number of cancers diagnosed at stages 1 and 2. We will reduce under 75 mortality from cancer considered preventable.	March 2028
Hospital discharge: We will further develop and implement efficient admission avoidance and hospital discharge processes, supported by digital automation and engagement with patients and their carers. We will put in place a long-term funding plan for discharge capacity. We will embed efficiency and process learning from transformation programmes into 'business as usual'.	We will have quicker and more effective discharge processes, reducing the length of the time people wait to be discharged and maximise reablement and independence after discharge. We will ensure that more patients are able to return to their usual place of residence following discharge, increasing Home First capacity, and decreasing reliance on bedded capacity. We will ensure discharge pathways allow for greater personalisation to meet the individual need of the patient and their carer.	March 2028
Multiple long-term conditions: We will implement a new integrated intermediate care model for rehabilitation and reablement services including a quality outcomes framework to demonstrate benefits.	We will improve the support for a short time to help more people and their carers to remain in their own home while they recover from a hospital stay.	March 2028

Difference this will make to local people and workforce in Brighton and Hove and how it will be measured

Difference for local people or workforce	How will this be measured
Multiple compound needs: Life expectancy will improve for people with multiple compound needs, reducing the current 34-year gap in life expectancy between this group and the general population. Services for people with multiple compound needs will be integrated and all service-users will have access to a lead professional who coordinates their care and support.	Through a clear outcomes framework, that is consistent across all partner organisations. Through a successful redesign and commissioning of services for people with multiple compound needs.
Health inequalities: Models of health, care and support that focus on prevention, greater independence and choice, self and proactive care including social prescribing through a locality-based integrated neighbourhood team model. This will be tailored to the individual needs within local neighbourhoods and our communities of interest.	Reduction in the numbers of people accessing hospital services in an unplanned way. Reduction in the gap in life expectancy and healthy life expectancy for communities with health inequalities. Reduction in new cases of HIV, with the aim to achieve zero transmission.
Children and young people: We will see a reduction in waiting times for emotional wellbeing treatment and support, with a greater focus on prevention and early intervention.	Reduced waiting times to access services. Reduction in referrals to specialist CAMHS services.
Mental Health: Life expectancy will improve for people with serious mental illness. Improved experience of people using services by reducing barriers between services and the need to re-tell their story, reducing the potential for re-traumatisation. Increase in availability of preventative support including suicide prevention.	Life expectancy data. Patient Reported Outcome Measures (PROMS). Measurement of suicide rate. Reduction in waiting times. Increase in number of people accessing services.

Improve access by making it easier and quicker to get support.	
Cancer: Improved take-up rates of FIT testing, including groups with low participation, particularly men, people from minority ethnic backgrounds and people from deprived areas. Targeted lung health checks will lead to an increase in lung cancers being diagnosed at an earlier stage.	Public Health Screening Data. Cancer Action Group Dashboard. Increase take-up rates of FIT testing by 7%. Increase lung cancer stage 1 diagnosis by 47%.
Multiple long-term conditions: Lower levels of mortality and disability due and cardiovascular disease. People will be better supported to remain at home and retain more independence in the community.	Increased levels of independence. 90% of the expected prevalence of Atrial Fibrillation is diagnosed. Reduced time waiting to receive reablement/intermediate care intervention. Reductions in people unnecessarily needing long term care. Reductions in need for care home placements. Increased proportion of care provided at home. Greater personalisation of discharge care and increase in number of personal health budgets and increase in proportion of people living independently at home for longer.
Hospital discharge: Improved discharge process to ensure people return home as appropriately as possible.	Reduction in the length of time between someone being ready to leave hospital and when they do. Maximise the proportion of people who can return home after leaving hospital.

East Sussex

Improving Lives Together and our East Sussex Health and Wellbeing Board Strategy to 2027 align around a shared vision where in the future health and care organisations will work in a more joined-up way with and within communities to better understand and respond to their specific needs. Support and services will be shaped around local people, rather than expect them to fit into the 'system'.

Delivering this requires a collaborative approach across all our organisations to improve health, reduce health inequalities and deliver integrated care for our population. In East Sussex, we have committed to some shared priorities and work based on the needs and assets in our population and the factors that influence people's overall health and ability to stay healthy, in addition to improving outcomes through integrated health and care. The focus of our shared work is aimed at increasing prevention and early intervention and delivering personalised, integrated care.

Our East Sussex Health and Care Partnership brings together the full spectrum of local partners responsible for planning and delivering health and care to our communities. We have comprehensive governance arrangements that support collective accountability between partner organisations for whole-system delivery and performance. The governance arrangements facilitate transparent decision-making and foster the culture and behaviours that enable system working.

Our ambitions for improving lives at place

Aligned to our system ambitions to develop Integrated Community Teams, we will build on our existing work to expand the integrated community model for our population that will better enable health, care and wellbeing for people and families across the whole of life. This will mean designing a model that best enables:

- Working together in our communities across Primary Care, community healthcare, education, social care, mental health, and the full range of local voluntary and community and housing organisations, and using our collective resources driven by a deeper shared understanding of local needs.
- Strengthening our offer of integrated care. For children and young people this will involve working with whole families and linking more closely with early years settings, schools, and colleges. For adults this includes further developing Trusted Assessor roles, rapid crisis response and support with discharges from hospital, as well as exploring ways to build more integrated leadership and roles to deliver better co-ordinated care.
- A clear focus on improving population health overall and therefore the years of life people spend in good health. This includes leisure, housing and environment services provided by borough and district councils and others.

How we will deliver our ambition

Our partnership plans to embed hubs within our integrated communities to help co-ordinate access to local sources of practical support and activities. We also want to

develop our plans for using our power as employers and buyers of services to stimulate economic and social wellbeing in our communities. This model will bring:

- Greater capacity in communities to promote mutual support, and deeper levels of joined-up and personalised care, building on the strengths and assets of individuals, families, and communities.
- Greater levels of prevention, early intervention, and ways to proactively respond to prevent situations getting worse.
- New ways to remove the barriers that prevent staff and volunteers working in different teams from working together on the ground.

Accountability through to our Health and Wellbeing Board and strong links into Sussex-wide programmes will enable a clear focus to be retained at Place on our key priority integration programmes across health improvement and reducing health inequalities, and integrated care for children and young people, mental health, and community services.

The actions we are taking this year (2023-24) to deliver our East Sussex Place-based priorities are:

What we will do	What we will achieve	When
Building on the Universal Healthcare initiative and other local programmes, we will have a joined-up approach to planning and delivering health, care, and wellbeing in Hastings, with clear evidence of integrated approaches to improving outcomes for local communities.	A planning and delivery approach agreed by Place leadership board.	March 2024
Service models will be developed and approved for scaling up across the county and an implementation timetable with key milestones agreed.	Service models will be approved by Place leadership board.	March 2024
A comprehensive stakeholder engagement process will take place to help us explore how we can improve health outcomes in cardiovascular disease (CVD) respiratory disease, mental health, and frailty/ageing as significant drivers of poor health and early death in our population.	Improvement plans approved by Place leadership board.	March 2024
Aligned to our discharge workstream, we will develop our integrated hospital discharge model, implement the 2023-24 hospital discharge capacity plan, and deliver the improvements aligned with the discharge frontrunner programme.	More people will be able to be discharged safely to a community setting.	March 2024

Our place-based discharge transformation work will happen to ensure efficiency within current processes.		
Deliver our children and young people's programme plan with a key focus on priority workstreams to support getting the best start in life; promoting emotional wellbeing and mental health; physical health, needs of children with SEND, and our most vulnerable young people.	Family hubs with additional support for families with young children; strengthened support for long term conditions (Core20PLUS5 for CYP); clearer and improved pathway for mental health support and support for parent carers.	March 2024
We will deliver initial stages of integrated models of community mental health care within local communities, through Primary Care Network based offers and developing plans to support more people who need housing-based support due to their mental health.	In-year plan delivered.	March 2024
Networks will be developed in communities to help co-ordinate access to local sources of practical support and activities, to boost emotional wellbeing and help with loneliness and isolation.	Consolidation of networks providing access and support to local people.	March 2024
Develop our approach as an "anchor" system in East Sussex, including our plans for using our power as employers and buyers of services to stimulate sustainable economic and social wellbeing in our communities.	Approach approved by Place leadership board.	March 2024

The actions we will take over years 2-5 to continue to deliver our East Sussex Place-based priorities are:

What we will do	What we will achieve	When
Refresh and implement further actions in targeted areas to support population health improvement and integrated care in our four target conditions.	Continuation of measurable plans to improve life expectancy and healthy life expectancy and reduce unplanned use of hospital services.	March 2025

Implement the improvements to cardiology and ophthalmology through reconfigured acute hospital services.	Agreed transformation plans fully implemented improving efficiency and outcomes for local people.	March 2025
Appraise and jointly respond to forthcoming national guidance and tools and system opportunities designed to support a joined-up offer of care at Place across Primary Care, community health, adult social care, mental health, public health, and housing services which relate to health and social care.	An agreed plan to further evolve our provider collaboration at Place to support delegated responsibility for services in scope, to deliver shared population priorities for improved population health and integrated care.	March 2025
Develop a reprofiling of resource application to support a widening of emotional wellbeing services for children and young people.	Improved access to emotional health and wellbeing services that support improved experience for children and young people and reduce the need for more specialist care.	March 2026
Enhance support to families to enable the best start in life including continued development of an integrated pre and post-natal offer.	Improved experience and increased opportunities to support our most vulnerable families.	March 2026
Implement integrated community-based approaches for mental health and a wider range of early support for mental health, in-line with Sussex-wide approaches.	Reduced reliance on specialist services and improved population health and wellbeing.	March 2026
Continue phased implementation and evolution of locality-based Integrated Community Teams model.	An approach and model supported by comprehensive engagement and fully owned and embedded with communities that delivers integrated support in local communities.	March 2028

Aligned to the discharge workstream, we will further develop and implement efficient hospital discharge processes, supported by digital automation, with a long-term funding plan for discharge capacity. We will embed efficiency and process learning from transformation programmes into 'business as usual'.	We will have quicker and more effective discharge processes, reducing the length of the time people wait to be discharged and maximise reablement and independence after discharge, ensuring more patients are able to return to their usual place of residence following discharge, increasing Home First capacity, and decreasing reliance on bedded capacity. We will also ensure discharge pathways allow for greater personalisation to meet the needs of individuals and carers.	March 2028

Difference this will make to local people and workforce in East Sussex and how it will be measured

Difference for local people and workforce	How will this be measured
People will be supported to stay healthy for longer and more proactive preventative care will be available for those who need it, across the full range of organisations that can support this.	Reduction in the numbers of people accessing hospital services in an unplanned way. Reduction in the gap in life expectancy and healthy life expectancy.
More children and young people will be accessing assessment and treatment more quickly and will be supported to live healthier lives.	Improvements in health outcomes. Increase in the proportion of children and young people with a diagnosable mental health condition who receive treatment from an NHS-funded community mental health service.
More people will be able to access support with their mental health needs more quickly and closer to home and there will be more intensive bespoke housing-based options for people who need it to ensure people can leave hospital more quickly when they are ready. Staff roles will become more manageable and more enjoyable.	Reduction in the number of inappropriate referrals to mental health secondary services, and an increase in appropriate referrals to secondary mental health services improving outcomes, reducing waiting times and preventing issues from worsening.

Community care and support will be better co-ordinated to enable people to stay independent for longer, have better onward care after a spell in hospital, and ensure access to local sources of practical support and activities, boost emotional wellbeing, and help with loneliness and isolation.	Increase in the number of people seen within the waiting time target for reablement services. Number of people living at home and accessing support in their communities. Proportion of people with support needs who are in paid employment. Proportion of people who regain independence after using services. Proportion of people and carers who report feeling safe. Reduction in the numbers of people accessing hospital services in an unplanned way. Reduction in the average length of stay in community beds. Reduction in the average length of stay in Discharge to Assess (D2A) commissioned beds and increased use of D2A bed capacity utilisation.
People have access to timely and responsive care, including access to emergency hospital services when they need them.	Reduction in waiting times for GP services, community support and care services. Referral times for health treatment. Reduction in the length of time between somebody being ready to leave hospital and when they do.
Digital services and innovation are used to help make best use of resources.	Proportion of people and staff in all health and care settings able to retrieve relevant information about an individual's care from their local system.

West Sussex

Our West Sussex Health and Wellbeing Board has a Joint Health and Wellbeing Strategy 2019-2024 called "Start Well, Live Well, Age Well". It sets out the Health and Wellbeing Board's vision, goals, and ways in which we will work to improve health and wellbeing for all residents in West Sussex. It was developed in consultation and collaboration with local residents, service users, multi-disciplinary professionals, and partners. It draws on evidence of West Sussex's health and wellbeing needs from the Joint Strategic Needs Assessment (JSNA).

The strategy adopts a life course approach, identifying our priorities across three themes - Starting Well, Living and Working Well and Ageing well. It consists of a few carefully selected priorities that can significantly contribute towards achieving its vision with a focus on:

- A whole system approach to prioritise prevention, deliver person-centred care, and tackle health inequalities.
- Harnessing the assets and strengths of local communities to improve health and wellbeing, creating safe, sustainable environments that promote healthy living.

The West Sussex Health and Care Partnership was formed in 2020, bringing together key local health and care partner organisations to work collaboratively to deliver the objectives of the Joint Health and Wellbeing Strategy and the Sussex-wide strategy through a Place-based plan. The partnership leads on delivering shared population health objectives on behalf of the Health and Wellbeing Board.

We have developed a model of collaboration that brings changes to people directly within their community, through our Local Community Networks. These are co-located with district and borough footprints and are empowering communities to deliver change through collaborative working between Primary Care, district and borough councils, local Public Health, and voluntary sector enterprises. We will maintain our focus in year one on how Local Community Networks can continue to make the positive changes for people who live in West Sussex, as we develop our Integrated Community Team model across Sussex.

Our ambitions for improving lives at place

Our West Sussex Health and Care Partnership responds to the challenges faced collaboratively as a group of organisations and the delivery of the priorities set out in *Improving Lives Together*. Our strategic goals are:

- **Address health inequalities**: There are stark inequalities in outcomes, access, and experience of care for maternity and neonatal service users and the opportunities and experience of staff from minority backgrounds and we will tailor our services to target the needs of our local populations and offer a personalised maternity journey that wraps around the individual and their family. We will prioritise the improvement of healthy life expectancy through tackling the key health inequality related conditions and ill health relating to CVD, respiratory and cancer. We will utilise approaches such as tobacco

control, cancer screening and health checks and work together with key stakeholders across the area to target our activity and resources where it is needed most based on need and evidence of what works. We will make care more personalised so that people can access health and care services that are more tailored to their needs, make sense to them and focus on what really matters in their lives.

- **Integrate models of care**: We have opportunities to further develop how our services work together to streamline pathways for patients, improve experience and create more integrated approaches. Through integrated services we will remove the unnecessary barriers between our services that are all working to support the same local people and create more sustainable models of care.
- **Transform the way we do things**: We will continue to improve our services where it will have the greatest impact, taking the opportunity to address health inequalities and strengthen our integrated approach. We will continually review our joint transformation priorities year-on-year, systematically improving our services.

How we will deliver our ambition

The West Sussex Health and Care Partnership Place-based Plan uses evidence from the Joint Health and Wellbeing Strategy to determine local priorities and key areas for change agreed across our partners and within the framework of the ambitions outlined above. To support the delivery of the system-wide priorities and our strategic goals, there are six specific priority areas for change that have been identified from the Health and Wellbeing Strategy for West Sussex:

- **Tackling the wider determinants of health**: We will work together to influence the many determinants of healthy living, such as how services are accessed and how communities can be empowered to support healthy living for their residents.
- **Addressing health inequalities**: We will have a targeted and focused approach for those with most need and who need additional support.
- **Adults Services**: We want to help people 'live the life they want to lead', by remaining independent for as long as possible and maintaining a high quality of life.
- **Children and Young People**: We will improve the existing support to children and young people so they can have the best possible start to life, through our West Sussex Children First programme.
- **Mental Health**: We will expand our support for people with mental health needs to address the growing need, delivering the best standard of physical health checks for people with mental illness, and developing sustainable housing solutions for people living with long-term mental illness.
- **Learning Disabilities and Neurodevelopmental needs**: We will provide greater focus and support for those with a learning disability and neurodevelopmental needs, by reforming our children's and young people's neurodevelopmental diagnosis and care pathway, including social support.

The actions we are taking this year (2023-24) to deliver our West Sussex Place-based priorities are:

What we will do	What we will achieve	When
We will develop and agree a business case and implementation plan for a new Bognor Diagnostics Academic Centre. We will develop education, training and develop courses to support local people in gaining employment in this sector.	We will be able to provide additional capacity for diagnostic tests.	September 2023 March 2024
We will complete a public consultation, produce, and agree a business case and start to mobilise a new model for stroke services in the coastal area of West Sussex subject to the outcomes of the public consultation. We will develop our cardiovascular disease reduction priorities in West Sussex including hypertension case finding and treatment, and the restoration of the NHS health checks programme.	We will be able to become fully compliant with national standards for acute stroke services. The West Sussex Cardiovascular Disease Reduction action plan will be developed and monitored at the West Sussex Cardiovascular Disease Reduction group.	December 2023 March 2024
Aligned to the Integrated Community Frontrunner programme, we will develop new models of care for our priority services in Crawley, produce and agree the business cases (including impact measures) and implementation plans for our four priority service areas and a strategic outline case for improvement to our estates.	We will be able to tailor our services and improve access for the most disadvantaged communities in Crawley. This includes the development of a new Community Diagnostics Centre at Crawley Hospital, and new improved facilities for the Child Development Centre at Crawley Hospital.	March 2024
Aligned to the discharge workstream, we will develop our integrated hospital discharge model, implement the 2023-24 hospital discharge capacity plan, and deliver the improvements aligned with the discharge frontrunner programme.	We will be able to ensure people who no longer need acute inpatient care can go home or to a community setting to continue recovery. We will also ensure Place-based discharge pathways are	March 2024

Our Place-based discharge transformation work will happen to ensure efficiency within current processes.	aligned to national best practice and achieving maximum efficiency.	
We will develop a new integrated intermediate care model for rehabilitation and reablement services and a business case and implementation plan for the new model.	We will be able to ensure people receive rehabilitation and reablement care in a timely manner, through teams working together in reducing unnecessary duplication and handovers.	March 2024
We will create an emotional wellbeing pathway focused on ensuring that the best outcomes are achieved for children and young people and embed training at point of induction for social workers and annual refreshers thereafter.	We will be able to improve the support and interventions for children and young people with autism and or mental health issues.	March 2024
We will review our joint commissioning arrangements for learning disabilities, mental health, and neurodevelopmental services.	A robust and transparent Section 75 agreement which sets outs the joint and pooled commissioning and provider arrangements between West Sussex Adult Social Care and NHS Sussex West Place to meet the needs of residents. This will enable the introduction of new clinical governance measures on Case Review Process to ensure best practice and compliance to new regulations.	March 2024

The actions we will take over years 2-5 to continue to deliver our West Sussex Place-based priorities are:

What we will do	What we will achieve	When
We will implement tailored health services and service models for our priority service areas in Crawley to meet the needs of the population with a focus on the most disadvantaged communities.	We will increase service use by the most disadvantaged communities in Crawley. We will have improved health outcomes for the most disadvantaged communities.	March 2028

	We will have co-ordinated utilisation of estates and assets across health and social care.	
We will deliver the Bognor Diagnostics Academic Centre.	We will contribute to the West Sussex diagnostic programme to enhance access to diagnostics for patients across Sussex with our CDC capacity, improved diagnostics pathway, and capital investment in services. We will increase in numbers of physiological and imaging workforce being trained or being employed.	March 2028
We will create access to 24/7 acute stroke centres for the coastal area of West Sussex, subject to the outcome of public consultation. We will further develop and implement seamless rehabilitation pathways to ensure people can return home as soon as their acute episode is resolved. We will implement our cardiovascular disease reduction priorities.	We will have a fully compliant stroke pathway from prevention through to hyper-acute care to rehabilitation in place for the population. We will have better long-term outcomes for patients and their carers and reduced mortality/ disability due to stroke and cardiovascular disease.	March 2028
We will further develop and implement efficient hospital discharge processes, supported by digital automation. We will put in place a long-term funding plan for discharge capacity. We will embed efficiency and process learning from transformation programmes into 'business as usual'.	We will have quicker and more effective discharge processes, reducing the length of the time people wait to be discharged and maximise reablement and independence after discharge. We will ensure more patients are able to return to their usual place of residence following discharge, increasing Home First capacity, and decreasing reliance on bedded capacity. We will ensure discharge pathways allow for greater personalisation to meet the needs of the individual and their carer.	March 2028

We will implement a new integrated intermediate care model for rehabilitation and reablement services including a quality outcomes framework to demonstrate benefits.	We will improve the support for a short time to help more people remain in their own home while they recover from a hospital stay.	March 2028
We will implement a new emotional wellbeing pathway to further support and interventions for children and young people with autism and or mental health issues.	We will ensure that within 24 hours of admittance to a paediatric ward due to autism, learning disabilities or mental health concerns, there is a multi-disciplinary plan to ensure a discharge in-line with their best interest.	March 2028
We will continue with our Joint Commissioning Review in West Sussex to further enable delivery of the priorities set out in *Improving Lives Together*, the Adult Social Care Strategy, and the Children First Strategy.	We will reform our joint commissioning governance to support the continued development of integrated health and care partnership working at system, Place and local community level. We will realign our strategic and financial joint commissioning arrangements to match our local population health priorities, and the priorities set out in our health and care strategic plans.	March 2028

Difference this will make to local people and workforce in West Sussex and how it will be measured

Difference for local people and workforce	How will this be measured
Improved health outcomes for the most disadvantaged communities in Crawley.	Improved health outcomes across a number of areas including maternity, mental health, and long-term conditions. Improved access across a range of services for our most disadvantaged communities. Increase uptake of translation services, more services available outside 9-5, Monday to Friday.
Improved access and capacity of diagnostics in Bognor	People will have access to their diagnostics at more convenient times. Reduced waiting times for diagnostics. Local residents in local university diagnostics related courses. Increased workforce supply, skills mix and new roles across imaging workforce.
Lower levels of mortality and disability due to stroke and cardiovascular disease.	Increased number admitted to stroke ward within four hours and spend 90% of their time there. More lives saved 90 days post discharge. Increased levels of independence. 90% of the expected prevalence of Atrial Fibrillation is diagnosed in every practice in West Sussex. 90% of people already known to be at high risk of stroke are adequately anticoagulated.

Improved discharge process to ensure people return home as appropriately as possible.	Reduction in the length of time between someone being ready to leave hospital and when they do. Reduction in overall number of patients who are ready to leave hospital but cannot. Maximise the proportion of people who can return home after leaving hospital.
People will be better supported to remain at home and retain more independence in the community.	Reduced time waiting to receive reablement/intermediate care intervention. Reductions in people unnecessarily needing long-term care. Reductions in need for care home placements. Increased proportion of care provided at home. Greater personalisation of discharge care and increase in number of personal health budgets. Increase in proportion of people living independently at home for longer.
Improved outcomes for children and young people with autism and mental health issues	Within 24 hours of admittance to a paediatric ward due to autism, learning disabilities or mental health concerns there is a multi-disciplinary plan to ensure a discharge in line with their best interest. Mental health, autism and learning disability module for social workers at university.
A shared set of strategic priorities and plans with integrated and streamlined commissioning arrangements and use of resources supporting delivery.	By streamlining and strategically aligning the West Sussex Joint Commissioning activities between local government and the NHS to population health priorities for children and young people, people living with a learning disability or neurodiversity or long-term mental illness, we will aim to deliver:

	• Care models that enable greater independence, choice, and self-care. • Greater technology enabled care to support more people to live independently at home. • Better long-term health outcomes by tacking health inequalities experienced by people with learning disabilities, or mental illness.

SECTION 6
Other areas of focus

To support the delivery of our ambition and the four delivery areas, there are other areas that will require continued focus, either within the actions of our improvement priorities or as distinct pieces of work. These are set out below.

Prevention

Prevention is a key principle that underpins the delivery of our ambition. This includes supporting good physical health, supporting people to be socially connected, supporting emotional wellness and positive mental wellbeing, supporting people to feel safe in a clean and sustainable environment. The work being undertaken to deliver our Health and Wellbeing Strategies has prevention as a core focus and this will be taken further with the development of our Integrated Community Teams.

We are committed to the delivery of our Sussex Improving Population Health Strategy and the key priorities in the Sussex Strategic Framework for Health Inequalities. We continue to embed Population Health Management methods to identify target populations for health conditions, prevention programmes, racial health disparities and focussed personalised care interventions. We also have a series of programmes of work to address Core20PLUS5 for children, young people, and adults.

Increasing our focus on addressing the needs of children and young people is also an important element of our commitment to prevention. Using the system Children and Young People's Board to ensure that the work of all our Delivery Boards address the needs of children and young people will help us to identify and take opportunities, where we can, increasingly to shift the profile of our investment into prevention while still continuing to provide the health and care needed across our population.

We will measure the success of our prevention work through:

- An increase in healthy life expectancy for males and females and a reduction in the inequalities in healthy life expectancy.
- A reduction in the prevalence of overweight children in reception and year six of primary school.
- An increase in the percentage of children and adults meeting the recommended levels of physical activity.
- Meeting national targets for vaccinations and immunisations.
- A reduction in rates of emergency admissions and subsequent loss of independence due to falls.

- More adult social care users and adult carers have as much social contact as they would like.
- More people aged 40-74 offered and taking up an NHS Health Check.

Maternity and Neonatal Care

Maternity service reviews undertaken across England identified the need to proactively identify Trusts that require support before serious issues arise. To safeguard Sussex residents using our perinatal services, we must ensure we can identify adverse outcomes early and act swiftly whilst we embed learning from these national investigation reports. The processes and ways of working we have developed across our local maternity and neonatal system (LMNS) partners will continue to support our response to key national reports, Ockenden and Reading the Signals.

NHS England published the three-year Maternity and Neonatal Delivery Plan which details the national ambition of ensuring that care is safer, more personalised, and equitable and based around the themes below. NHS Sussex is collaborating with the LNMS to develop provider and system plans to respond to these recommendations.

- Listening to, and working with, women/people and their families with compassion.
- Growing, retaining, and supporting the workforce.
- Developing and sustaining a culture of safety, learning and support.
- Standards and structures that underpin safer, more personalised, and more equitable care.

Safeguarding

We want to ensure all children, adults, families, and communities across Sussex are safe and free from all forms of abuse and harm. This involves a whole-system multi-agency approach that crosses all ages, places where people live and work, communities, and systems.

NHS Sussex has an agreed strategic approach to maintain safe and effective safeguarding and Looked After Children services and to strengthen arrangements for safeguarding children and adults at risk from abuse and neglect across Sussex. We are required to demonstrate how our strategic and assurance arrangements enable us to carry out the duties and functions specified under the Care Act (2014) and the Children and Social Work Act (2017). We have an extensive and wide-reaching approach which includes:

- Clear systems to train staff to recognise and report safeguarding issues.
- A clear line of accountability for safeguarding and Looked After Children, reflected in our governance arrangements and overseen by NHS England.
- Arrangements to work with local authorities through our Safeguarding Children Partnerships and Safeguarding Adult Boards.
- Arrangements to share information between service providers, agencies, and commissioners.

- Designated doctors and nurses who are responsible for safeguarding adults, children and looked after children.
- A child death review team, who are responsible for reviewing deaths in childhood, including nurses and a designated doctor.
- Child Protection Information Sharing (CP-IS) will continue to be rolled out across Sussex.

Quality

NHS Sussex has a statutory duty to ensure quality of care is maintained across services and meets the Care Quality Commission minimum standards for quality and safety, and that our health and care organisations have systems in place to check the quality and safety of care provided. Our quality assurance and improvement frameworks support our workforce in ensuring that our populations experience the best possible care. We will know that we are making a difference because:

- People that inspect our health services will agree that they are safe and the measures for rating our services, such as those set out by the Care Quality Commission (CQC) will have improved.
- Our workforce will tell us that our services are improving in quality. By April 2024 we will have co-produced meaningful measures of quality and safety with our people and communities as well as an improvement target for the subsequent five years.
- People will report a better experience of contacting our Primary Care services.
- Our staff will be able to talk about and report quality and safety concerns freely without fear of speaking up or being criticised.
- There will be evidence that we are working more closely and better together to improve quality, responding to complaints more quickly, and running educational events to teach people how to create better quality and safety in our integrated services.

Supporting social and economic development

Supporting local social and economic development across Sussex is one of the core aims of achieving our ambition. This will be done through our focus on the wider determinants of health across local people and communities, including access to education and skills, good employment and quality, affordable and sustainable homes – all the things that can help people and communities to thrive and prevent the need for medical intervention and give people the best opportunities for improving their lives.

We want to develop our health and care organisations into ‘anchor institutions’, where they will use their sizeable assets and ways of working to support the health and wellbeing of local communities and help address health inequalities. NHS Sussex is committed to using its evolving anchor role to explore and develop new networks across the region with the intention of establishing a greater understanding of the cross-sector impacts of health inequalities in Sussex and enabling policymakers from the system and wider sectors to come together to share ideas

and develop health focused solutions. A growing socioeconomic challenge in the region and a significant determinant of a healthy and happy life is housing, from quality and accessibility to affordability, NHS Sussex will work with established and new partners to explore strategic options to tackle housing challenges.

This represents a new way of working for our system and it is recognised that it will take time to establish how partners can achieve this ambition most effectively together. To support this, in year one we will establish a baseline understanding of current work happening across the system that we can build on over years 2-5. This will include:

- Procurement activity which promotes local supply chains and local employment opportunities with a living wage.
- Employment initiatives that can assist with recruitment and retention of staff, as well as supporting the wider economy of Sussex.

Climate change commitments

Since 2010, the NHS has reduced its emissions by 30%, exceeding its commitments under the Climate Change Act. In doing so, we have learnt that many of the actions needed to tackle climate change will directly improve patient care and health and wellbeing. This is because many of the drivers of climate change are also the drivers of ill health and health inequalities.

Together to Zero is our plan for a greener NHS in Sussex. The plan sets out how we will work together as partner organisations across our system to reduce carbon emissions and build an NHS more resilient to the effects of climate change. It also sets out a number of key areas for action on climate change that pose the most significant co-benefits for health, and which drive at greater efficiency and productivity. The plan supports the individual organisational plans of our NHS providers and will support the effective delivery of our Integrated Community Teams and Health and Wellbeing Strategies.

Evidence, research, and change methodology

We want to be driven by the best evidence and be at the forefront of improving health and care in our communities. To do this we will generate and use research evidence and create a culture of innovation to bring the best new approaches to Sussex. A new group is being developed called the Innovation and Research Hub, which will aim for the first time to bring together a Sussex-wide approach to Innovation, Research and Evaluation. The Innovation and Research Hub will hold the relationships with academic and research networks, national bodies, universities, local economic groups, and national and local industry groups. The introduction of the Innovation and Research Hub will bring the most progressive approaches in healthcare into Sussex. Having a streamlined approach to evidence finding, impact analysis and implementation will reduce the time lost through the current fragmented approaches but also accelerate the introduction or spread of useful technologies, medicines, or practice.

SECTION 7
Developing and delivering our Shared Delivery Plan

Our Shared Delivery Plan meets national guidance and takes account of key national, regional, and local strategies and policies. In-line with guidance, we will review and update the plan before the start of each financial year. We may also revise the plan in-year if considered necessary.

Planning approach and principles

Three principles describing the Shared Delivery Plan's nature and function have been co-developed with systems across the country, Trusts and national organisations representing local authorities and other system partners. These are:

- Principle 1: Fully aligned with the wider system partnership's ambitions.
- Principle 2: Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments.
- Principle 3: Delivery focused, including specific objectives, trajectories, and milestones as appropriate.

Maximising the power of partnerships

Improving Lives Together outlines a commitment to maximising the power of partnerships to ensure organisations responsible for health and care work together in the best possible way for local people.

To enable the most effective delivery of our Shared Delivery Plan, it has been agreed that organisations will work together across four different levels:

- System level – across the whole of Sussex
- NHS provider level - across NHS organisations.
- Place level - across the footprints of our three local authorities.
- Local community level – to support the development and delivery of the Integrated Community Teams

This way of working will enable better integration of services, use of resources, co-ordination, planning, and decision-making that will lead to better joined-up care for local people and better ways of working for our staff. It also supports national policy and guidance. To enable this to happen, we are developing a new operating model across the system that will have a 'golden thread' of all organisations working in the best possible way for local people and patients. In doing so, we will respect the statutory and corporate accountabilities and responsibilities of all organisations.

This will require every statutory organisation to start to work in a new way across the four different levels from April 2024.

System level

We will continue to work at a Sussex-wide system level through the existing statutory architecture that was established with the formal formation of our Integrated Care System.

The Sussex Health and Care Assembly is the Integrated Care Partnership for Sussex, which is a joint committee established by NHS Sussex, Brighton and Hove City Council, East Sussex County Council and West Sussex County Council in accordance with the constitutions of each body. The membership of the Assembly includes wider partners, including our three Universities, further education, the housing sector, the local enterprise sector, Healthwatch, and the Voluntary Community and Social Enterprise sector. The purpose of the Assembly is to bring a broad section of system partners together to approve and facilitate the strategic direction for meeting the broader health, public health, and social care needs of the population. This allows for partnership and collaborative working to take place across wider partners.

NHS Sussex Integrated Care Board (ICB) is the statutory NHS organisation responsible for the oversight of performance, quality, and resource allocation of NHS services across Sussex. This is done by working with NHS providers and a legal obligation to work with Local Authority partners. The NHS Sussex Board is made up of independent Non-executive Directors, partner members from NHS providers, local authorities, and Primary Care, as well as Executives. The future function of NHS Sussex will change to be predominantly focused on the strategy and planning for the system to achieve improved outcomes for the population. A new operating model will be developed during 2023-24 and will be in place from 2024-25.

NHS provider level

A Provider Collaborative will be established, which will involve NHS providers working together in a more formal, effective, and joined-up way for the benefit of patients and staff. The collaborative will design the service transformation models to deliver the strategic priorities, in co-production with partners, at Place and local community level. The provider collaborative will include Primary Care as part of the membership.

Place level

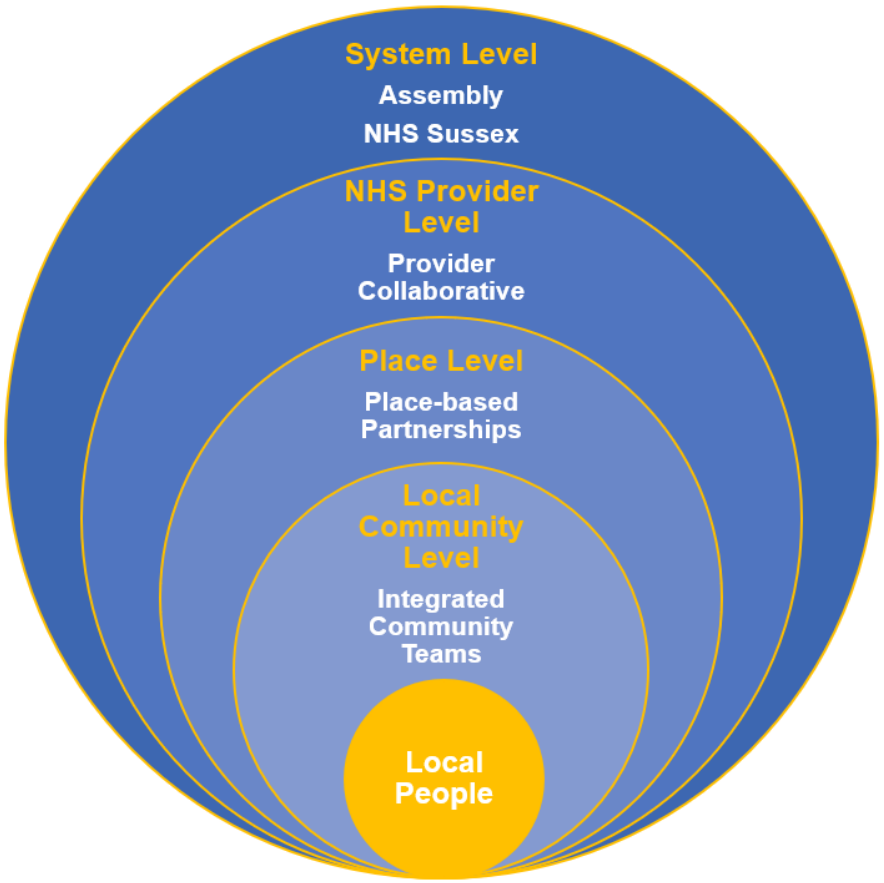
We will strengthen how our organisations work together across our populations in Brighton and Hove, East Sussex and West Sussex through Health and Care Partnerships and delivery of the Place-based Health and Wellbeing Strategies. Place will be the intermediary tier for the NHS and the primary tier for the Local Authority to discharge its statutory responsibilities to meet residents' needs in their council area. It will oversee and provide leadership for the delivery of services at community level and fulfilment of legal duties in respect of Place-based partnerships including with Health and Wellbeing Boards.

Local community level

We will integrate services and ways of working at a local community level through the formation of Integrated Community Teams. We are consciously using the term 'community', rather than 'neighbourhood' which is also often used to represent integration at a very local level, as we will have a broader focus on people's individual needs that will stretch beyond simply the geographical location they live. By community, we mean both the recognised local area someone lives and communities that people identify with, such as those with the same interest, beliefs or ways of life.

Integrated Community Teams will be the focus for prevention, self-care, and providing support to help people make choices about their care and look after their own health priorities, enabled by strengthened Primary Care and assets-based approaches with communities. They will be supported to develop new approaches across Sussex which will be based on empowering our communities, the promotion of local leadership, equality of partnership between participating organisations, a permission to innovate for local people and for staff, and a different approach to working with people. As our communities across Sussex are all unique, partner organisations will have to work in a pragmatic and flexible way at this level and will be supported to do so. This will involve changes to how partners have worked in the past to ensure they are able to work in an integrated way at a local level.

Figure 3: Strategic levels of joined-up working:



Governance and leadership

Governance for delivery

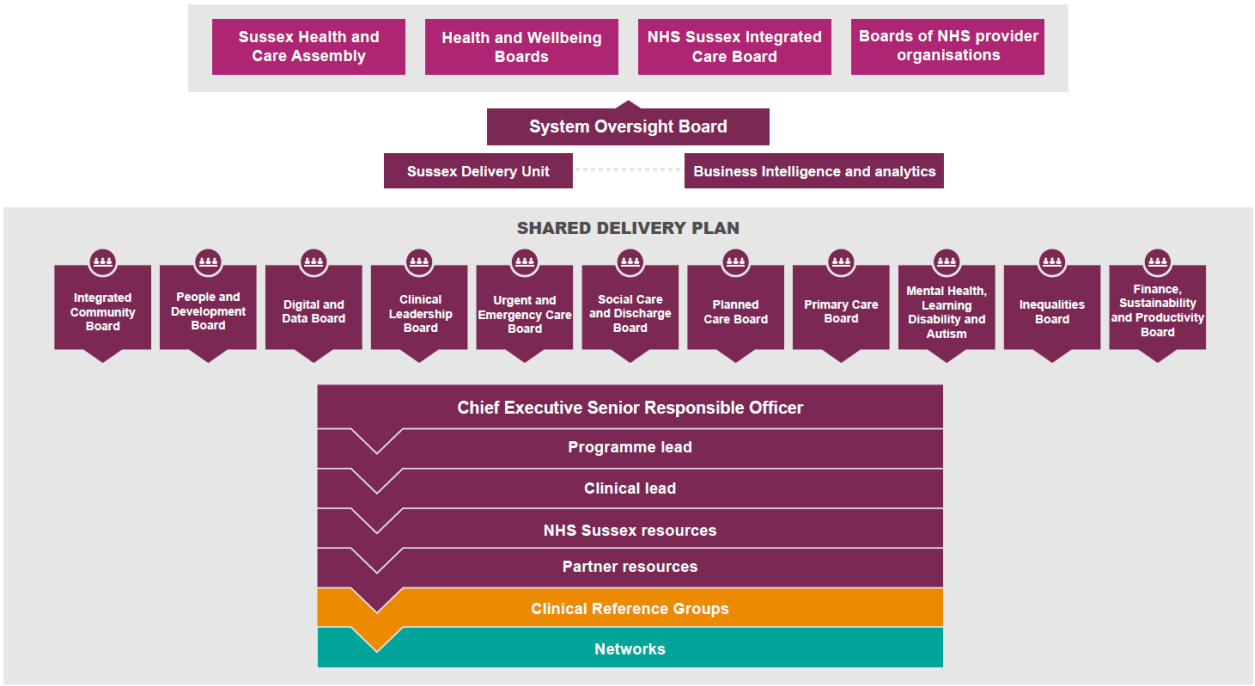
The delivery structure for the Shared Delivery Plan is outlined below. This involves each of our Long-term Improvement Priorities (Delivery Area 1), Immediate Improvement Priorities (Delivery Area 2) and Continuous Improvement Areas (Delivery Area 3) having a Delivery Board to lead the delivery of the agreed actions, chaired by a system Chief Executive Officer. Each will have a workstream that will be resourced from across system partners. The work of these Boards and workstreams will be overseen by a System Oversight Board.

Each workstream across Delivery Area 1 and 2 will give due regard to the continuous improvement areas and ensure they are embedded within the work taking place and all will ensure they are supporting the aims and ambitions of *Improving Lives Together* in:

- Improving health and health outcomes for local people across the life course, with particular focus on children and young people;
- Tackling health inequalities;
- Working better and smarter; and
- Supporting communities to develop socially and economically, including sustainability.

The delivery Boards will develop detailed workplans and milestones for each workstream and will use insight and data to create outcome frameworks.

Figure 4: Governance structure for delivery:



System Oversight Board

The core functions of the System Oversight Board (SOB) will be to oversee the implementation of the Shared Delivery Plan and to provide leadership with regards to strategy, and resolution of system risk.

SOB will report into the NHS Sussex Executive Committee and onwards to the NHS Sussex Board. Members will be required to report back from SOB through to their respective organisational boards and leadership forums to ensure system alignment. The new SOB replaces the former System Leadership Forum and is made up of Chief Executive Officers from the statutory NHS organisations, GP Federations, and senior representatives from the Local Authorities. This includes the leadership of Surrey and Sussex Healthcare NHS Trust.

Financial strategy and delivery plan

Work has taken place across the system to co-produce a plan to deliver our long-term strategic ambitions. However, it is important to recognise public sector financial constraints over a number of years, which therefore means delivery of this plan is subject to an underpinning financial strategy which will be developed by September 2023. As a result of this there may be further strategic and operational change required to underpin delivery over the next five years, the size and impact of which will need to be captured.

Engagement and partnerships

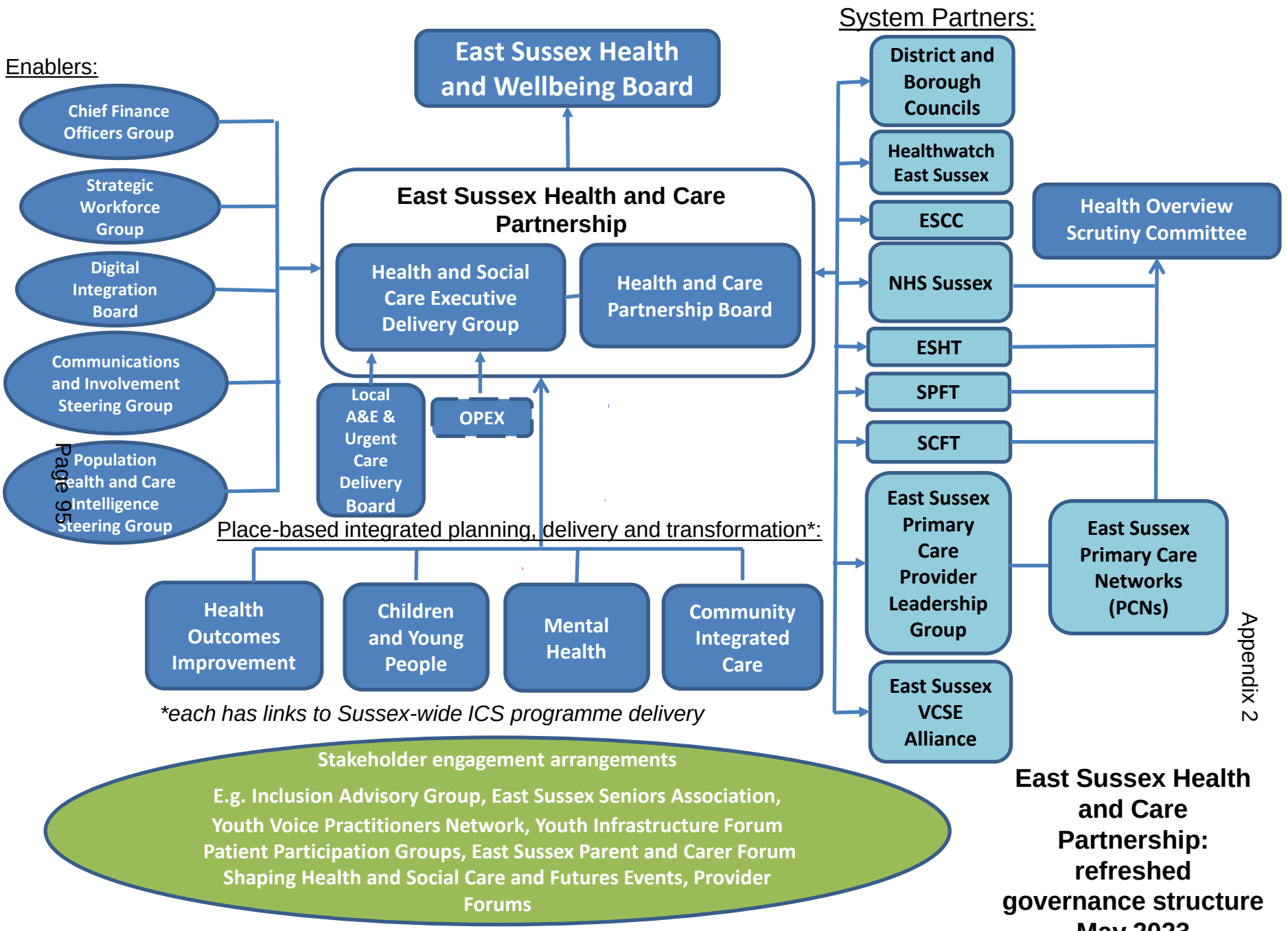
Our Shared Delivery Plan has been developed across system partners and is informed by national, regional, and local evidence, guidance, and insight. To support the co-development process, we have established an engagement working group, working with:

- The Sussex Health and Care Assembly members
- Primary Care providers
- Local Authorities and each relevant Health and Wellbeing Boards
- Other systems in respect of providers whose operating boundary spans multiple systems
- NHS providers
- Healthwatch
- The voluntary, community, and social enterprise sector
- People and communities that will be affected by specific parts of the proposed plan, or who are likely to have a significant interest in any of its objectives, in accordance with the requirement to consult.

Insight from engagement with people and communities across Sussex over a two-year period underpinned the development process of *Improving Lives Together*, and thematic analysis of this insight has informed the creation of the Shared Delivery Plan. Enhanced engagement opportunities were also offered via online sessions for Foundation Trust Governors and the public, discussions with members of the Sussex VCSE sector, Healthwatch and with other key partners.

Extensive workforce engagement was also undertaken with insight collated from the national NHS staff survey results and from NHS organisation and Local Authority "pulse" surveys.

As we deliver the actions outlined in our Shared Delivery Plan, we are committed to making sure we continue to reach and hear from as many people as possible across Sussex, and ensuring their experiences, views and suggestions shape and influence our work. Each Delivery workstream will set out how the public and patients will be involved and engaged as part of their workplans for the delivery of the agreed actions. Our Working with People and Communities Strategy outlines our approach to public engagement and how we meet the legal duties around involvement.



East Sussex Health and Care Partnership: refreshed governance structure May 2023

DETAIL programme governance for partnership planning, delivery and transformation at East Sussex Place level within the Sussex ICS

Strategic partnership enabling workstreams

- East Sussex Finance Directors Group
- East Sussex Strategic Workforce
- East Sussex Digital Integration Board
- East Sussex Communications and Involvement Steering Group
- New: Population Health and Care Intelligence Steering Group

East Sussex Health and Wellbeing Board

Sets the strategic direction based on the needs of the population (JSNA) and HWB Strategy; holds organisations to account for how well they work together to deliver the Strategy at Place

East Sussex Health and Care Partnership

- East Sussex Health and Social Care Executive Delivery Group
- East Sussex Health and Care Partnership Board

Agrees East Sussex Strategic Shared Delivery Plan

Aligned implementation and delivery at Place

Oversight and monitoring of shared delivery plans and programmes; ensures coordination across integration programme delivery (below)

Key Sussex-wide programmes:
- Children and young people programme
- Community Mental Health Transformation
- Integrated Community Teams

Suggested focus: strategic approach to:
- Joint intelligence and data about needs, service use and community profiles
- County-wide risk stratification and population segmentation framework
- Prioritisation of outcomes across the life course
- Coordination of learning across key relevant health inequalities programmes e.g.:
  - Universal Healthcare proposition
  - Making it Happen (asset-based community development)

New: Health Outcomes Improvement Oversight Board	Children and Young People Health Oversight Board	Mental Health Oversight Board	Community Oversight Board
Suggested focus: whole system health improvement lens (from wider determinants and prevention through to demand, service use and flow) to measurably improve outcomes for: • CVD • Respiratory disease • Frailty/healthy ageing • Mental health (all ages) Oversight of: • Core20Plus5; CYPCore20Plus5; maternity, and; cancer health inequalities work • Health improvement work programmes – alcohol; smoking; healthy weight	Ensuring children and young people have an integrated offer of health, social care and wellbeing: • Pathways and commissioning approach to Tier 4/ Secure/Specialist placements • Autism, ADHD, and other neurodevelopmental disorders pathways • Access to emotional wellbeing and mental health services • Best Start in Life	Ensuring adults and older people with mental health issues have an integrated offer of health, social care and wellbeing: • Integrated community and primary care services • Eating disorders pathway and services • Complex emotional needs pathway and services • Supported accommodation and housing	Ensuring older people and people of all ages with long term complex care needs have an integrated offer of health, social care and wellbeing: • Neighbourhood teams and target operating model • Strengthened links with community networks and voluntary and community sector support • Admission avoidance and urgent/rapid response • Hospital discharge • Social care and health interface for Trusted Assessor models and Virtual Wards

Oversight Boards: *each responsible for leading priority integration change programmes and coordinating delivery of short and medium term improvements in their*

East Sussex Health and Care Partnership Board
DRAFT Key messages from the meeting – 2nd June 2023

Background

Launched in September 2019, the East Sussex Health and Care Partnership Board (PB) is accountable to our East Sussex Health and Wellbeing Board, which oversees how well we work together as a system in East Sussex. This also feeds into our Sussex Integrated Care System (ICS). Through aligning organisational plans across health, social care and wellbeing at Place (East Sussex) within our ICS, the focus for the Partnership Board is to coordinate and help shape the following developments:

- *Our East Sussex Health and Wellbeing Board Strategy 'Healthy Lives, Healthy People' (2022 – 27) and associated partnership plans, which set out **what** we need to do to drive the developments required to meet the health and care needs of our population and improve health outcomes. This is done through agreeing our local priorities for collaboration and our contribution to the wider Sussex Integrated Care Strategy, to help achieve NHS Long Term Plan ambitions*
- *Our proposals for **how** our organisations can best organise ourselves to deliver our plans as a place-based partnership in 2023/24 and beyond, as described in our Shared Delivery Plan*
- *Further developing our approach to population health and care commissioning in East Sussex to deliver improved **outcomes** and reduce health inequalities*

The membership embraces broad representation to help impact on the wider determinants of health. This includes East Sussex Healthcare NHS Trust, Sussex Community NHS Foundation Trust, Sussex Partnership NHS Foundation Trust, East Sussex borough and district councils, Healthwatch and the East Sussex Voluntary, Community and Social Enterprise (VCSE) Alliance and the twelve Primary Care Networks in East Sussex, alongside NHS Sussex and East Sussex County Council as statutory health and social care commissioners. Everyone on the Partnership Board (PB) feeds back to a broader constituency, and we have agreed to capture the key messages from each meeting to support this.

Introduction

The Partnership Board met on the **2 June 2023** and reviewed the draft Sussex Integrated Care Strategy Shared Delivery Plan (SDP) from the perspective of the East Sussex population, building on initial discussions at the meeting in March 2023. This focus in March was on the high-level milestones being developed to support delivery of shared priorities in the following areas in 2023/24:

- Ongoing focus on our existing shared delivery priorities aimed at improving population health and increasing prevention, early intervention and integrated care across the services for children and young people, mental health, community, urgent care and planned care.
- Within this there was support for two new areas of focus in 2023/24:
    - Collaborating to co-design and deliver 'whole system' pathway improvements for cardiovascular disease (CVD), respiratory disease, mental health and frailty/healthy ageing, to both improve health outcomes in the long term and impact on current need for services.
    - Developing the 'proof-of-concept' for the core Integrated Community Teams model to support integrated health, care and wellbeing. In East Sussex this will be tested and developed in Hastings, with further phases of implementation activity across the county.

At that time, members of the Board were keen to engage further with crafting and determining what integrated community teams means for East Sussex, with a clear message around what it means for our populations and making best use of the opportunities to underpin the existing assets and networks that support broader resilience in communities. This included making best use of strategic alliances with the Voluntary, Community and Social Enterprise (VCSE) sector at both a Place (East Sussex) level and an ICS (Sussex) level where helpful.

Key messages from the 2nd June meeting

At the June meeting the full draft Sussex Shared Delivery Plan was considered, including further detail about the East Sussex milestones and refreshed partnership and programme governance to support delivery at the Sussex and Place level, with the following views:

- Overall support for the Shared Delivery Plan and the three areas of delivery covering shared Sussex Strategy long term improvements, immediate and continuous areas of improvement for the NHS, and the fourth covering delivery of the three HWB Strategies and plans specifically for East Sussex, West Sussex and Brighton and Hove.
- The comprehensive nature of pulling together delivery targets across the totality of NHS delivery alongside partnership plans that focus on shared priorities was recognised, with the need to connect financial targets together with activity changes, and widening access to services to support recovery in the most efficient way.
- The holistic approach being taken to improving health outcomes in East Sussex was welcomed, as this will ensure a strong focus on prevention as well as better and more joined up care for those who need it. It was felt that the proposed changes to our partnership programme governance to reflect this new priority focus would support effective delivery, enabling us to join up the work on health outcomes with our model for integrated community teams.
- In relation to the proposed eleven Sussex-wide Delivery Boards there was enthusiasm to be involved, balanced with the need to be clear about the nature of partnership priorities and where collective energy and effort will add the most value. It was felt that sharing representation on some of the Boards collectively across Places and sectors will help to ensure our capacity can focus on local implementation and delivery of plans.
- In the context of investing energy in new alliances emerging at a Sussex level to enable a helpful focus on areas of commonality and Sussex-wide approaches (for example for the VCSE), the importance of having the space to maintain collaborative relationships that have built up over time to support delivery capacity with partners in local areas to meet the needs of local people, was also underlined.
- Similarly, liaison with the NHS Integrated Care Board (ICB) about healthcare issues that are common across Sussex is helpful for the three Healthwatch organisations to undertake collectively.
- To complement the existing strong arrangements across the huge amount of activity and services working together at a Place level to ensure children and young people have the best start in life, and that this continues well into adulthood, a pan-Sussex approach will be extremely valuable to forward some aspects of children and young people's services, for example where care needs and pathways are complex.
- Overall, time should be given for new statutory ICS arrangements to continue to mature and enable shared understanding to grow about the issues and challenges, and where working together on a pan-Sussex level across all three Places will realise benefits through increasing momentum and pace.

The other items reviewed at the meeting were as follows:

- The Partnership formally agreed minor changes to update the Partnership Board terms of reference as part of the East Sussex Health and Care Partnership governance refresh exercise, ensuring it is fit for purpose to mutually oversee delivery of East Sussex plans and milestones in the SDP. These will be used as a working document in 2023/24 as the roles of Sussex and Place continue to be developed.

- The Partnership Board agreed to champion and advocate a new approach to the creative arts in Public Health across our membership and constituencies as part of wider work on Culture and Public Health strategies in the County. Evidence shows that the creative arts are a crucial resource that can mitigate against the ill effects of social health determinants and protect mental health and wellbeing, supported through actions that cut across the public, private and voluntary sectors. Creative interventions have been associated with improvements in well-being and social wellbeing, slower declines in cognition, reduced levels of isolation and loneliness and lower mortality rates. The new focus will help to ensure that current good practice, awareness of the population health benefits, and commissioning practice can be strengthened to widen access to the benefits across our whole population.
- The Partnership Board also considered the findings from the Healthwatch Listening Tour in Eastbourne were also discussed, in response to the Health and Wellbeing Board's request. The members of the Board agreed to use the recommendations and messages to help inform organisations' plans where appropriate, and provide feedback at the next meeting.

Background notes on the Sussex Integrated Care Strategy Shared Delivery Plan

The Sussex Integrated Care Strategy '*Improving Lives Together'* was agreed by the Sussex Health and Care Assembly in December 2022 following endorsement by the East Sussex Health and Wellbeing Board at its meeting on 13 December. The Sussex Strategy builds on our East Sussex Health and Wellbeing Strategy '*Healthy Lives, Healthy People'* (2022 – 2027), and sets out our ambition for a healthier future for everyone in Sussex over the next five years. It includes the following priorities:

- Building on the partnership working that has developed across health and care, including the Place-based Health and Care Partnerships that report into the three Health and Wellbeing Boards, and building integrated community teams
- Growing and supporting our Sussex health and care workforce
- Improving the use of digital technology and information, and;

Covering the period 2022 – 2027, the *Improving Lives Together* aims to improve the lives of everyone living in Sussex now and in the future and will address the needs of all our communities. Covering all ages across the whole life course it will:

- Help local people start their lives well;
- Help local people to live their lives well;
- Help local people to age well;
- Help local people get the treatment, care and support they need when they do become ill.

This ambition is focussed on a new community-based approach, which will work with and within different communities to better understand local population needs and respond in the best possible way. Overall, this will enable a greater focus on keeping people healthy, supporting all aspects of people's lives and the specific needs of children and young people.

To support this a 5-year joint forward plan (known in Sussex as the Shared Delivery Plan or SDP) is being brought together. This will support alignment of our key partnership delivery plans across the Sussex Integrated Care Strategy and the East Sussex HWB Strategy, at a Sussex and Place (East Sussex) level, and delivery of the annual NHS Operational priorities for 2023/24.

An initial draft SDP focussing on year 1 (2023/24) milestones was submitted to NHSE in March 2023, and endorsed for further development by our NHS ICB. The finalised SDP will be submitted to NHSE by 30 June 2023 and will cover the high-level milestones for year 1 and a roadmap for delivery in years 2-5. As part of the development of the SDP, the East Sussex Health and Wellbeing Board (HWB) must determine whether the draft plan takes proper account of HWB strategies and plans.

For more information please contact: Vicky Smith, Programme Director – East Sussex Health and Care Transformation: vicky.smith@eastsussex.gov.uk

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Report to: **East Sussex Health and Wellbeing Board**

Date: **27 June 2023**

By: **Director of Adult Social Care and Health**

Title: **Better Care Fund Plans 2023-25**

Purpose of Report: **To provide a summary of the Better Care Fund (BCF) requirements for 2023 - 2025 and to seek approval of the East Sussex BCF plans.**

Recommendations:

East Sussex Health and Wellbeing Board is recommended to:

1. **Note the Better Care Fund requirements for 2023-25**
2. **Approve the East Sussex Better Care Fund Plans for 2023-25 recognising the 2024/25 plans are subject to review later this year.**

---

1 Background

1.1 Since 2014 the Better Care Fund (BCF) has provided a mechanism for joint health, housing and social care planning and commissioning, focusing on personalised, integrated approaches to health and care that support people to remain independent at home or to return to independence after an episode in hospital. It brings together ring-fenced budgets from NHS Integrated Care Board (ICB) allocations, and funding paid directly to Local Government, including the Disabled Facilities Grant (DFG) and the improved Better Care Fund (iBCF).

1.2 For the next two years, the Additional Discharge Funding to enhance community and social care capacity is also required to be included in the BCF pooled budget arrangements.

1.3 The continuation of national conditions and requirements of the BCF in recent years has provided opportunities for health and care partners to build on their plans to embed joint working and integrated care further. This includes working collaboratively to bring together funding streams and maximise the impact on outcomes for communities whilst sustaining vital community provision.

2 National BCF Planning Guidance and Requirements for 2023-25

2.1 The BCF Policy Framework and Planning Requirements for the next 2 years were published on 5th April with local plans to be submitted by 28th June.

2.2 The Better Care Fund plans for 2023/25 include:

- A completed planning template which confirms the expenditure plan meets the national conditions and the East Sussex ambitions to progress performance against the identified metrics (Appendix 2). This template also includes local

capacity and demand modelling outlining the available capacity and predicted demand for intermediate care services for the remainder of 2023/24.

- A narrative plan outlining how the Better Care Fund is used in East Sussex to support local priorities including integration, hospital discharge, support for unpaid carers, collaboration with housing and addressing equality and health inequalities (Appendix 1). The narrative also outlines lessons learnt from 2022/23 and how these have influenced the BCF Plans for 2023-25 and shaped the ambitions to deliver the BCF priorities and metrics.

- Areas are asked to demonstrate how the additional Discharge funding is intended to provide increased investment in social care and community capacity to support discharge and free up beds.

2.3 BCF National Conditions:

The national conditions for the fund are broadly like 2022-23 and continue to require a minimum spend level on social care and community health services.

1. Plans to be jointly agreed.
2. Enabling people to stay well, safe and independent at home for longer.
3. Provide the right care in the right place at the right time.
4. Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services.

2.4 BCF Metrics:

The metrics included in the planning template for this year are:

Metric	Detail
Avoidable admissions	Unplanned Admissions for chronic ambulatory care sensitive conditions (NHS OF 2.3i)
Falls Admissions	Emergency hospital admissions due to falls in people over 65
Residential care admissions	Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes. (ASCOF 2A part 2)
Effectiveness of reablement	People over 65 still at home 91 days after discharge from hospital with reablement (ASCOF 2B part 1)
Discharge destination	Percentage of discharges to a person's usual place of residence (SUS data)

The BCF Planning guidance advises of new metrics to be introduced in later this year and next year.

Expected in Q3 2023/24	Discharge metric
New for 2024/25	Proportion of people discharged who are still at home after 91 days
	Outcomes following short-term support to maximise independence.

3 East Sussex Better Care Plans 2023-25

3.1 The vision for the BCF over 2023-25 is to support people to live healthy, independent, and dignified lives, through joining up health, social care, and housing services seamlessly around the person. This vision is underpinned by the two core BCF objectives:

- Enable people to stay well, safe and independent at home for longer.
- Provide the right care in the right place at the right time.

3.2 As with previous years the East Sussex Better Care Fund plan is developed and delivered within the context set by the:

- Healthy lives, healthy people: East Sussex Health and Wellbeing Board Strategy 2022-2027

Healthy lives, healthy people: East Sussex Health and Wellbeing Board Strategy | East Sussex County Council

- Improving Lives Together: Our ambition for a healthier future in Sussex - built upon the Health and Wellbeing Strategies of the three Sussex 'places':

https://www.sussex.ics.nhs.uk/wp-content/uploads/sites/9/2023/01/0438-NHS-Sussex-VF4-4.pdf

- Improving Lives Together: Sussex Integrated Care Board Shared Delivery Plan – five-year shared Delivery Plan including specific East Sussex ambitions and actions.

3.3 The NHS minimum contribution for has risen by 5.66% for 2023/24 with the same rise mandated for 2024/25.

3.4 Additional Discharge funding for 2023/24 has been allocated to Local Authorities (LAs) and the ICB to be included in the BCF. For 2024/25, Better Care Fund Plans should assume LA Discharge funding will increase by 66%. The ICB is required to agree with local Health and Wellbeing Boards how the ICB element of Discharge funding will be allocated at HWB level rather than being set as part of overall BCF allocations, this being based on allocations proportionate to local area need.

3.5 Improved Better Care Fund (iBCF) and Disabled Facilities Grant (DFG) conditions remain as previous years and the allocations for each remain at the 2022/23 rate for both years of these plans.

3.6 Adult Social Care contribution and NHS commissioned out of Hospital services ringfences have increased in line with the overall increase i.e., 5.66%

3.7 Contributions to the Better Care Fund for the next 2 years have been confirmed and agreed as:

Funding Source	Lead Org	2023/24 Contributions	2024/25 Contributions
NHS Minimum Contribution	NHS Sussex ICB	£49,618,443	£52,426,847
Carers	ESCC	£694,000	£694,000
Disabled Facilities Grant	ESCC	£8,123,612	£8,123,612
Improved Better Care Fund	ESCC	£21,776,611	£21,776,611
Discharge Funding	ESCC	£3,053,047	£5,068,058
Discharge Funding	NHS Sussex ICB	£3,537,522	£5,024,117
Total BCF Resources		**£86,803,235**	**£93,113,245**

3.8 The BCF funded schemes, having been reviewed to ensure they are aligned with plans for East Sussex and the local population, are carried forward from the previous year with the following additions:

- Discharge Fund: LA Grant and ICB Allocation. The schemes funded by the Discharge Fund fall fully within the BCF plan following the initial roll-out in Q4 2022/23.

- For 2023/24, the ICB will fund additional hospital discharge schemes via the BCF.

3.9 The previous Section 75 agreement which facilitates the pooling of the Better Care Fund in East Sussex will be updated for 2023/25 once these plans have been approved.

3.10 Following submission, regional and national assurance processes will be undertaken with final assurance expected on 8th September 2023.

3.11 It is recognised that areas may wish to amend plans for 2024-25, following sign off and assurance, to:

- modify or decommission schemes.
- increase investment or include new schemes.

4 Conclusion and reasons for recommendations

4.1 This paper summarises the Better Care Fund requirements for this year and sets out the East Sussex plans confirming their alignment with the national conditions and delivery of the wider transformation of the health and care system locally.

4.2 The Health and Wellbeing Board is asked to:

1. Note the Better Care Fund requirements for 2023-25.

2. Approve the East Sussex Better Care Fund Plans for 2023-25 recognising the 2024/25 plans are subject to review later this year.

MARK STAINTON
Director of Adult Social Care and Health

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Appendix 1: East Sussex HWB Better Care Fund Narrative Plan 2023-2025

Appendix 2: East Sussex HWB Better Care Fund Planning Template 2023-2025

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Better Care Fund Narrative Plan

2023-2025

East Sussex Health & Wellbeing Board

June 2023

Contents

1. Stakeholder Engagement

In East Sussex, an integrated approach across the NHS, local government and wider voluntary and independent sector services plays a key role in developing all our local plans which align to the Better Care Fund (BCF) plans. At a local level this integration is managed through the East Sussex Health and Care Partnership which brings together:

East Sussex County Council (ESCC)
NHS Sussex Integrated Care Board (ICB)
East Sussex Healthcare NHS Trust (ESHT)
Sussex Community NHS Foundation Trust (SCFT) and Sussex Partnership NHS Foundation Trust (SPFT)
Primary Care Networks (PCNs)
District and Borough Councils (including Housing)
Healthwatch
Voluntary, Community and Social Enterprise (VCSE) Alliance
East Sussex Fire and Rescue Service
South East Coast Ambulance Service
Education Providers, Registered Landlords, and a wide range of public and private organisations.

The overall purpose of the East Sussex Health and Care Partnership is to support delivery of our locally agreed plans and programmes of transformation for the recovery, stabilisation and future sustainability of our health and care system. Our aim is to work together as a system to ensure a focus on prevention and deliver high quality, effective care, and improved health outcomes, and the operational models that enable this, for the population in East Sussex.

Through a partnership approach the East Sussex Health and Care Partnership has the following key roles:

1. Supporting the ongoing development and implementation of a 5-year integrated local East Sussex Plan which forms part of the Sussex-wide Integrated Care Strategy ***Improving Lives Together***.

2. Supporting the delivery of initial agreed priority programmes of transformation in three core areas of urgent care, planned care and community services, and

3. Ensuring engagement with the delivery of the plans and collectively tackling the issues and challenges we face as a system.

We work with our citizens in a range of ways to ensure that the way our priorities are delivered fits with what people have told us is important about their health and care. This includes Healthwatch and Young Healthwatch, Youth Infrastructure Forum, the Mental Health Action Group, East Sussex Seniors Association, and patient participation groups. Meetings have also been held with partners to discuss specific aspects of the East Sussex BCF plans and ensure a collaborative and cohesive approach to their development.

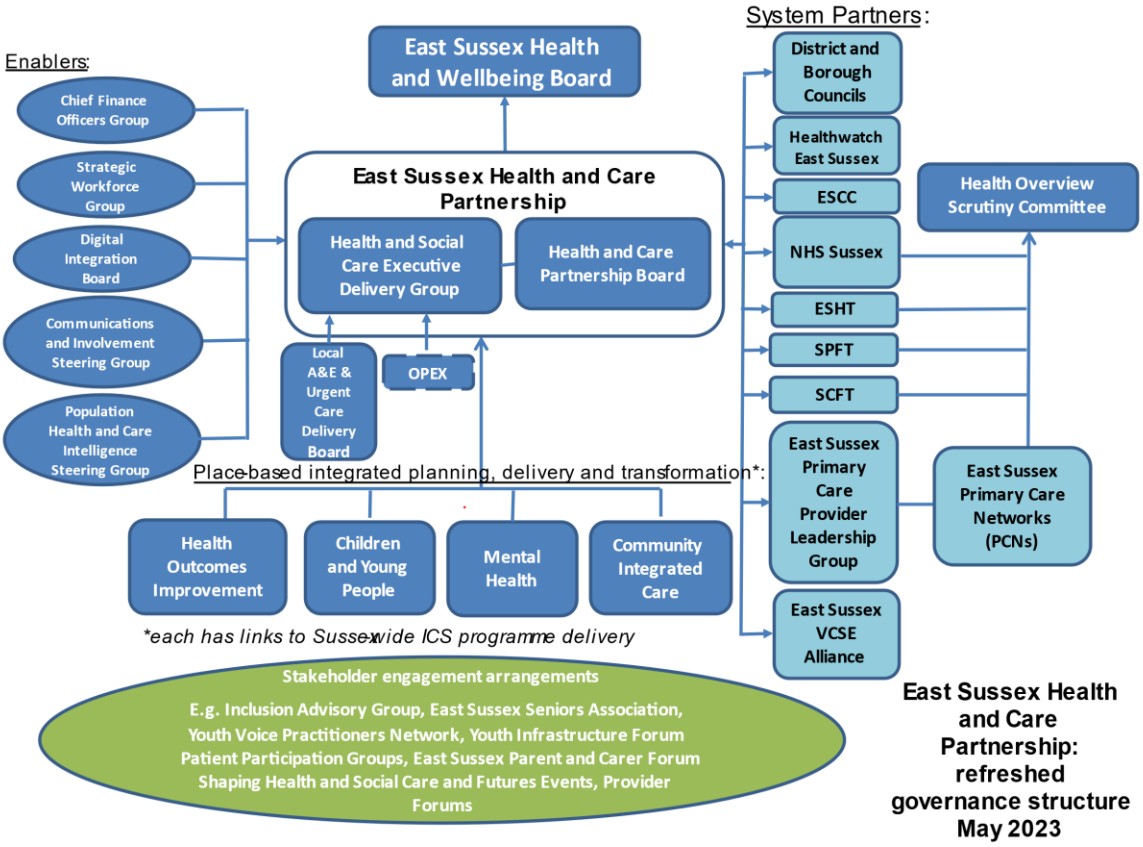
In addition to approval of the plan there is ongoing and regular stakeholder engagement via established forums. For example, with our providers in respect of discharge planning and

monitoring, system performance, capacity and demand planning, and at individual scheme level with NHS providers, social care providers, VCSE providers, and housing authorities.

2. Governance

East Sussex is one of three places in our Sussex ICS (alongside West Sussex and Brighton and Hove) that are working together to deliver our shared priorities through a shared plan. The East Sussex Health and Wellbeing Strategy provides an overall framework for our partnership work in East Sussex, and with the public, aimed at improving the health and wellbeing of local people and transforming the way we provide health and care.

Our established place-based system partnership governance has evolved over four years since its inception in 2019. During that time core membership across the range of system partners has remained relatively stable, and programme governance has been used to support delivery of shared priorities originally set out in our East Sussex Health and Social Care Plan (March 2020), which brought together County Council priorities and NHS Long Term Plan commitments.



The East Sussex Better Care Fund plan is developed and delivered within the context set by the:

- Healthy lives, healthy people: East Sussex Health and Wellbeing Board Strategy 2022-2027

Healthy lives, healthy people: East Sussex Health and Wellbeing Board Strategy | East Sussex County Council

- Improving Lives Together: Our ambition for a healthier future in Sussex - built upon the Health and Wellbeing Strategies of the three Sussex 'places':

  https://www.sussex.ics.nhs.uk/wp-content/uploads/sites/9/2023/01/0438-NHS-Sussex-VF4-4.pdf

- Improving Lives Together: Sussex Integrated Care Board Shared Delivery Plan – five-year Shared Delivery Plan including specific East Sussex ambitions and actions.

How the application of the Better Care Fund, including the Discharge Funds, supports the delivery of the Sussex Shared Delivery Plan, is captured through the Sussex system oversight governance arrangements. East Sussex governance arrangements link to the Shared Delivery Plan and System Oversight governance that encompasses health and social care, to ensure alignment of plans and benefits realisation through the current and future deployment of the BCF.

3. Executive summary

The vision of the East Sussex Health and Wellbeing Board is to protect and improve health and wellbeing and reduce health inequalities in East Sussex, so that everyone has the opportunity to have a life that is as safe, healthy, happy, and fulfilling as possible.
For health and care services, our aim is to work towards a fully integrated health and care system and by doing this we will ensure people receive high quality, coordinated care, enabling them to live good lives.

Priorities for 2023-25

There are common themes throughout all the East Sussex priorities which will be a part of everything we deliver over the next three to five years. These are:

- improving health and reducing health inequalities
- improved access to local services
- bringing together health and social care
- urgent and emergency care.

The Better Care Fund will continue to play a significant role in the driving improvement in all of these areas through the integration and pooling of resources to support delivery of our shared priorities.

Key changes since previous BCF plan.

The Sussex-wide Integrated Care Strategy ***Improving Lives Together*** was launched late in 2022/23 providing a strategic approach for ensuring the Better Care Fund across all parts of Sussex is focused on delivery of the key priority delivery areas via a Shared Delivery Plan.

To support these delivery areas, the BCF funded schemes are carried forward from the previous year with the following additions:

- Discharge Fund: Local Authority (LA) Grant and ICB Allocation. The schemes funded by the Discharge Fund fall fully within the BCF plan following the initial roll-out in Quarter 4 (January – March) 2022/23.
- For 2023/24, the ICB will fund additional hospital discharge schemes via the BCF.

4. National Condition 1: BCF plan and approach to integration

The vision of the East Sussex Health and Wellbeing Board is to protect and improve health and wellbeing and reduce health inequalities in East Sussex, so that everyone has the opportunity to have a life that is as safe, healthy, happy and fulfilling as possible.

For health and care services, our aim is to work towards a fully integrated health and care system and by doing this we will ensure people receive high quality, coordinated care, enabling them to live good lives.

East Sussex joint priorities for 2023-25

Through our partnership work, we will focus on a small number of shared priorities where we can achieve better results if we work together to offer more integrated care.
There are common themes throughout all the East Sussex priorities which will be a part of everything we deliver over the next three to five years. These are:

1. Improving health and reducing health inequalities by building on our existing progress to:
    - empower people to stay healthy and well for as long as possible.
    - reduce health inequalities and the gap in life expectancy and healthy life expectancy in the county.
2. Improved access to local services by improving the range of services available in the community.
3. Bringing together health and social care by removing barriers between our health and social care teams to support very frail and vulnerable people with long-term complex care needs and conditions.
4. Urgent and emergency care by making sure people get seen in the right place, at the right time by the right healthcare professional.

All the schemes within our BCF plans contribute to delivering these priorities and themes, and there are a range of wider commissioning and delivery plans which cover specific services and objectives in more detail.

The East Sussex approaches to joint/collaborative commissioning.

Our East Sussex Health and Care Partnership brings together the contributions of a range of partners to deliver this strategy, including the NHS, county, district, and borough councils, the voluntary, community and social enterprise sector, and Healthwatch East Sussex.
Together, we continue to explore the opportunities joining up care for people, places and populations and as part of our ICS to further strengthen collaboration on our priorities. These include more formal arrangements to plan services and share resources such as within the Better Care Fund, aimed at increasing integrated care and responding better to the needs of our population.

In delivering the vision and our priorities we recognise that:

- Working with people, carers, families, and communities is crucial to designing services and support that works. We will continue to build on the strengths of our communities, involving people in ways that suit them through a wide range of existing arrangements and new approaches.

- Healthwatch will continue to play a role at both a local and national level, ensuring that the views of the public and people of all ages who use health, care and other related public services are taken into account.
- Health and care services can offer joined-up high quality care that anticipates needs and intervenes as soon as possible, to have a positive impact on people's day-to-day life and deliver better outcomes.
- District and borough council actions have a positive effect on public health, and an enabling role in the health of their populations and communities through innovation in service delivery.
- Voluntary, community and social enterprise (VCSE) organisations play a key role in mobilising local social action that can bring communities together, both in times of need and more generally, as well as being a part of health and care delivery that supports people's health and wellbeing.
- Working together at a local and neighbourhood level with our partners will give a strong platform to deliver initiatives which improve health, wellbeing and services.

We continue to develop how we jointly commission and provide services, based on our knowledge of population's health and care needs and with a renewed focus on reducing health inequalities at the centre of everything we do, including:

- Proportionally targeting our resource to match the needs of individuals and communities to reduce the gap in life expectancy and to increase the quality of life.
- Having robust mechanisms to reach, hear from and better understand people and communities' experiences.
- Ensuring services are informed by both peoples' and communities' needs and assets.
- Connecting out knowledge of local health inequalities with front line service delivery.
- Taking action for people from pre-conception to after-death.
- Developing key performance indicators for addressing inequalities and supporting improved outcomes.

How BCF funded services are supporting our approach to continued integration of health and social care.

The services funded from the BCF in 2022/23 will continue to be funded for the next 2 years as they remain critical components of the system, by way of prevention or supporting system flow. All jointly funded and jointly commissioned BCF funded services contribute to delivery of the East Sussex plans for integration outlined above and support avoidance of admission to and reduced length of stay in bedded care, either directly or indirectly.

Alongside this, the Discharge Funding will be used to ensure people are transferred to an appropriate setting after an acute episode in order to maximise their outcomes and opportunities to return to independent living.

5. National Condition 2: Enabling people to stay well, safe, and independent at home for longer.

The East Sussex Better Care Fund Plans support the delivery of the East Sussex Health and Social care plans which address the local needs identified, the vision for integrating health and social care and to enable people to stay well, safe, and independent at home for longer whilst providing the right care in the right place at the right time.

Our steps to personalise care and deliver asset-based approaches.

The focus of our shared work on health and care services is aimed at increasing prevention and early intervention and delivering personalised, integrated care across services.

Through the BCF and wider programmes, we will continue to enhance community services and strengthen our overall model for integrated community health and social care services in our neighbourhoods and localities. Working with our Primary Care Networks and local VCSE organisations we will use information about local populations to better understand and target the needs and risks of particular groups, aimed at:

- increasing opportunities for proactive care and prevention across the wide range of local services that can improve health, wellbeing, and care, and reduce health inequalities in our communities.
- better supporting people with long-term complex care needs and their carers in their own homes, care homes and other community settings through embedding proactive and seamless wraparound care, including when people are at the end of their lives.
- further developing Trusted Assessor roles, rapid crisis response and support with discharges from hospital, as well as exploring ways to build more integrated leadership and roles to deliver better coordinated care.

A project called ‘Universal Healthcare’ is already underway in Hastings with a number of community engagement workshops having taken place to understand the needs of local people and help shape how they can be better supported in the long term. We intend to be able to start new ways of working and this is a good example of the way we want to work with our communities in future.

Our approaches to population health management, and proactive care, and how our schemes commissioned through the BCF support these approaches.

Our East Sussex Health and Care Partnership has a set of shared priorities drawn from the East Sussex HWB Strategy which are set out as four programmes all aimed at delivering improved health, care and wellbeing and reduced health inequalities based on the needs of our population. The overall focus of our shared work on health and care services is aimed at changing the way we make access to services and support available for people locally, increasing prevention and early intervention and delivering personalised, integrated care.

Population health management, prevention and health Inequalities are key areas of focus within the East Sussex delivery plan. Our shared priorities are to:

- Address the physiological causes of ill health to prevent premature death and the overall prevalence of disease.
- Support individuals and populations to adopt healthy behaviours.
- Address psychosocial factors and the wider determinants of health in our communities.
- Strengthen our capability as a system.

Through services funded via the BCF, we work closely with local VCSE organisations to support these approaches through ensuring that everyone is able to access:

- Clear advice on staying well.
- A range of preventative services
- Simple, joined up care and treatment when this is needed.
- Digital services (with non-digital alternatives) that put the citizen at the heart of their own care.
- Proactive support that keeps people as well as possible, where they are vulnerable or at high risk.

These BCF funded services in East Sussex include community hubs, community connectors, benefits advice, and access to community-based support for people with sensory and mental health needs.

Our development of multidisciplinary teams at place or neighbourhood level

In East Sussex, we will take the opportunity to expand and enhance our model for the way all our teams can work together in communities and neighbourhoods and removing the barriers between our organisations to enable them to do this.

- Use a specific site to test and develop a 'proof of concept' model:
- Test and develop our approach together; the suggestion is to focus on Hastings initially, followed by further phases of similar activity to roll the model out across the county.
- Build on the existing related services and projects.
- Build on our original target operating model for community services to ensure primary care, mental health and services that impact on the wider determinants of health and wellbeing are fully a part of the model.

Our work to support unpaid carers and deliver housing adaptations on delivering this objective.

A wide range of services to support unpaid carers are funded through the BCF including:

- ASC undertakes Carers assessments and reviews with allocation of a Carers Personal Budget as required to meet identified eligible needs.
- Carers reviews also offered by Care for the Carers – pilot project.
- Young Carers assessments/reviews undertaken by commissioned young carers provider.
- Carers assessments/reviews for carers of people living with dementia included in Dementia Support Service
- Carer respite allocated as a service to the cared for person.

- East Sussex Carers Centre offers information, advice, support, peer support groups, engagement opportunities, counselling, Carers Card (emergency plan, discounts), respite funding for healthcare appointments and training.
- Targeted support for carers of people with severe mental illness
- Carer identification and targeted support through primary care in Hastings and the Havens
- Short breaks provided through a volunteer respite service.
- Carer crisis service - short term interventions to meet agreed outcomes.
- Range of services provided through small grants – dementia training, cookery & arts activities, targeted support for BAME carers, carer support in hospices, digital support, lunch & supper clubs.
- Telephone befriending

Adapting the home can increase the usability of the home environment and enable people to maintain their independence for as long as possible. This has been shown to reduce the risk of falls and other accidents, relieve pressures on accident and emergency services, speed hospital discharge and reduce the need for residential care. Provision of home adaptations is likely to alleviate pressure on unpaid carers and enable disabled people to assess the wider community.

Secondment of specialist Adult Social Care Occupational therapy housing teams into District and Borough Councils in 2019 has allowed for provision of integrated, co-located housing related services including housing adaptations and a move away from the more traditional non-integrated two-tier approach that was previously employed in East Sussex.

This joining up at an operational level as recommended in the DFG review 2018 has enabled a single point of referral, simplification and speeding up of the client journey and an increase in the number of major and minor adaptations, where adaptations are not possible the Occupational Therapist can assist with exploring options available to them and advise about the most appropriate housing solution to meet their needs.

The team use prevention and personalisation to reduce health inequalities, supporting people to live as independently as possible through a greater focus on outcomes and the wider determinants of health in our community, and enabling more people to access more adaptations at the right time for them.

Five unqualified Occupational Therapy (OT) staff have received training to enable them to carry out a Trusted Assessor role allowing the assessment and recommendation from simple Disabled Facilities Grant (DFG) adaptations such as stairlifts and level access showers, enabling qualified OT staff to focus on the more complex assessments.

Referral routes have been streamlined and are accepted from a wide variety of sources, preventing delays in accessing services, consistency of approaches across areas provides greater equality. Closer working between organisations has meant more timely access to the service and an ability to resolve problems as they occur and with minimal impact on the tenants.

Referrals are screened and triaged based upon a priority and those where risks are highest or requiring support to be discharged are prioritised.

The team can access the full suite of Adult Social Care support by completing Care Act Assessments and are trained in assessing equipment, adaptations, telecare, carers

assessments, mental capacity, and safeguarding, they can provide daily living equipment and minor adaptations via the local Integrated Community Equipment service.

They work collaboratively with colleagues from Social Care, Wheelchair services, Health, Voluntary and Housing sectors to consider options to meet individuals' needs.

An innovative example is accessing funds for a 'third party top-up' towards a wheelchair provided by the wheelchair services to enable an additional rise and fall element to be fitted to the seat of the chair, allowing the individual to access higher shelves within their kitchen but also assisting them to access shelves within their local supermarket and have conversations at eye level.

Support is provided with rehousing; either via accessing discretionary assistance to finance moving costs, part-buy schemes to purchase an adaptable property (recently cited as an example of Best Practice by Foundations) or local housing registers. Options are fully explained and referrals to organisations such as Brighton Housing trust or internal Housing Solutions workers made. Assessments of temporary accommodation and adaptations and equipment in alternative housing are also carried out. Interim risk management measures are also provided.

Assessments are undertaken for individuals regardless of whether they live in public or private sector housing. For individuals who are identified as self-funding adaptations are offered information and advice to ensure their needs are appropriately met.

This service has successfully won the DFG team of the year award by Foundations in 2022.

Innovative applications of Housing Assistance Policies across the District and Borough Councils in East Sussex have enabled a larger number of residents to access home adaptations via support such as:

- Flexible application of financial means testing
- Addition of adaptations outside of the mandatory DFG framework (ie Dementia assistance grants to support people with dementia to retain independence at home for longer)
- Additional funding over the mandatory £30,000 mandatory limit
- Identifying high risk situations – such as falls accessing stairs and speeding up processes for accessing solutions to reduce risks.
- Hospital discharge grants including assistance with deep clean/decluttering.
- Support to relocate where existing property is not suitable for adaptations.

Our rationale for our estimates of demand and capacity for intermediate care to support people in the community.

Learning from 2022-23

- There is variable access to Pathway 1 services due to geographical areas of challenge in respect of the availability of onward care capacity.
- The current processes for referral to Discharge to Assess (D2A) are complex and there is a need to simplify the existing pathway.
- These will be forward as part of Hospital Discharge transformation and Discharge Front Runner programme.

Our approach

Demand Assumptions:

- Demand for 'Urgent Community Response' is based on referrals received in 22/23, excluding those received from acute services.
- Demand for other services arising from community sources is based on best estimates and analysis of supporting Hospital Discharge estimates.

Capacity Assumptions

- Reablement and Rehabilitation at Home and in a bedded setting are as for Hospital Discharge
- Capacity is linked to demand as the best current indicator of capacity.

Significant Demand and Capacity Gaps

- Rehabilitation in a bedded setting: As for Hospital Discharge, demand exceeds capacity, primarily in the south and east of the County. This is a focus of Discharge transformation and use of discharge capacity.

Further work to refine the data is being undertaken as part of the Discharge Front Runner programme, this will include data for Mental Health pathways.

How East Sussex HWB is using the Better Care Fund to Enable people to stay well, safe, and independent at home for longer.

The transformation programme, service redesign schemes and developments are significantly wider than those funded by the Better Care Fund however the BCF plans for 2023/25 seek to support people to stay well safe and independent at home for longer through:

1. Enhanced prevention, personalisation and reducing health inequalities.
    - Falls and Fracture Prevention Programme as part of the ESHT community programme.
    - A range of services provided by the Voluntary, Community and Social Enterprise sector.

2. Support for people with mental health needs by ensuring access to a full range of services including:
    - Improved access to psychological therapies
    - Dementia services

3. Continue to integrate health and social care services and work with our Primary Care Networks to embed proactive anticipatory care, and seamless wrap around care to people with long term care needs and conditions and those in care homes.
    - Frailty services
    - Carers Services
    - Health and Social Care Connect (Single point of Access)
    - Housing support and adaptations

- Maintaining social care services
- Community Equipment services

4. Improve services that deliver planned care for local people.
    - Diabetes self-management and pharmacy support
    - Medicines Optimisation in Care Homes
    - Dietician support to medicines management

These BCF schemes support the delivery of the BCF metrics with many of these schemes being jointly commissioned and jointly provided by Adult Social Care and local NHS Trusts. The schemes support the development of integrated local service delivery and the move towards planning and designing services around local communities as a cornerstone of our vision for integrating care and support.

Although attribution at scheme level can be difficult, the funded services together with the overall approach to supporting this policy objective are expected to have a positive impact on unplanned admissions to hospital for chronic ambulatory care sensitive conditions, emergency hospital admissions following a fall for people over the age of 65, and the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

6. National Condition 3: Provide the right care in the right place at the right time.

Our ongoing arrangements to embed a Home First approach.

A key priority for improving discharge continues to be the Home First (HF) pathway, ensuring as many people as possible are discharged home from a stay in an acute hospital or community bedded setting. HF underpins our delivery of a Discharge to Assess (D2A) approach, enabling people to come home as soon as they are medically ready, with support wrapped around them by joint Health and Social Care service. This will include:

- Implementing a strategic approach to our enhanced Discharge to Assess (D2A) services to improve outcomes for patients, including linking this to other services such as rehabilitation and reablement and pharmacy support.
- Reviewing our proposed integrated urgent community response model across acute, community health and social care. This will support people to avoid going into hospital where there is a better alternative service and enable them to get home quickly when they are ready to leave hospital.
- Identifying and implementing Trusted Assessor opportunities, for example NHS staff being able to commission simple social care packages and telecare.
- Supporting the local implementation of 'virtual wards' to increase proactive care coordination at home for very frail people with complex care needs.

Our approach to improving discharge.

Our discharge improvement and transformation programme is being delivered within our SDP Discharge and Social Care Board, supported by our participation in the national Discharge Front Runner programme.

The selection of Sussex as a Discharge Front Runner will enable the existing initiatives to be built on and taken further to make greater improvements for local people.

Discharge Front Runners will involve local health and social care partners being supported to work together to rapidly find innovative solutions and new approaches, which have the potential to make a substantial difference to improving discharge across the country. They will specifically look at how workforce, data and digital, and intermediate care, can be better used to speed up discharges.

As part of the Discharge Front Runner programme our system is undertaking a comprehensive hospital discharge patient needs analysis, building on the work completed last year, which will be the underlying evidence base for our transition and future models.

Place-based initiatives are enabled through our system wide prioritised approach to developing the following to underpin our agreed model:

- A joint workforce planning framework across health and social care including the care provider market.

- Widen our scope of digital innovations.
- Business intelligence management tools: working towards a live tracking system to support demand modelling, performance improvement and operational oversight.
- Move to more innovative funding approaches as part of the total economic model to achieve more sustainable contracting, delivery, and better value for money.
- Delivery of a programme of discharge improvement at system, place, and provider level.

What we achieved last Winter

- Co-ordinated the identification and delivery of place-based schemes and associated prioritisation for capacity investment in relation to the £300m National Adult Social Care Fund and £200m Discharge Fund.

- Rolled out 100 Day Challenge High Impact Actions to Community and Mental Health providers building upon internal discharge improvement work undertaken within our community and mental health providers.

- Improved system visibility of data with the development of a system discharge dashboard covering a wide range of key performance indicators.

- Developed a new system Choice Policy based upon best practice, which has been agreed by all stakeholders and is being implemented in Q1 of 2023/24 supported by the provision of training for staff involved in discharge.

- Completed a review of the three Sussex discharge hubs against nationally published best practice guidance to inform the Transfer of Care Hub development for 2023/24

- Maintained the number of Medically Ready for Discharge (MRDs) at Quarter 1 (April–June) 2022/23 baseline levels over the Winter period with improvements in East Sussex.

- In Q4 of 2022/23 delivered an improvement in weekend discharges across the acute hospital sites.

What we learnt over Winter

- That there is a need to consider the cultural changes required to deliver and embed systemic improvements and to ensure that there is sufficient change capacity and capability in place to support implementation.

- That the short notice, non-recurrent nature of additional discharge funding made available for Winter resulted in the purchase of additional capacity, limited to the care market's ability to respond, which could not always be fully aligned to the strategic needs of the system, e.g. Interim care home beds for short-term placements with constrained onward care capacity and stretched assessment resources.

- It is important to ensure consistency around data and flow so performance management and strategic direction setting can be more closely aligned.

- It was identified that there is a significant opportunity to utilise Personal Health Budgets going forward learning from the use of Personal Health Grants over the Winter Period.

Feedback from the national system discharge visit to East Sussex on 31st May 2023.

We will receive a letter setting out the areas that are recommended to be addressed. This is expected to include further work on the system ambition for improvement and plans to address unwarranted variation in processes. This will be reflected in further development of this plan and overseen by the Discharge Front Runner Programme, linking back to local BCF governance.

Additional discharge funding: How we will use the to deliver investment in social care and community capacity to support discharge and free up beds.

A number of schemes have been agreed following review of the schemes funded from the additional discharge funding in Q4 2022/23 where there is confidence they can be fully utilised in line with the capacity and demand modelling for 2023/24. These include:

- Home care: additional block hours to support hospital discharge.
- Weekend Discharge Team: additional capacity to facilitate hospital discharge at weekends.
- High Intensity Users/Mental Health Discharge Co-ordinators
- Additional Adult Social Care assessment capacity
- Personal Health Grants: small grants to support low level hospital discharges.
- Additional D2A Beds
- Assisted Discharge Home: additional capacity for this service provided by the British Red Cross to support low level hospital discharges.

Early plans for 2024/25 will continue to ensure the required capacity is available to support Home First pathways however this will be subject to review of the demand for and efficacy of each later in 2023/24. These plans also include therapy support to the additional beds to maximise people's independence and opportunities to return home.

Our rationale for our estimates of demand and capacity for intermediate care to support discharge from hospital.

Learning from 2022/23

- There is variable access to Pathway 1 Home First Urgent Community Response (UCR) services due to geographical areas of challenge in respect of the availability of onward care capacity.
- The current processes for referral to Discharge to Assess (D2A) pathways are complex and there is a need to simplify the existing pathway.
- Assessment capacity to meet all demands including timely assessments to support discharge was a challenge over the winter period.
- Complex cases remain a key issue, where clients' clinical needs are high requiring specialist input from a range of professionals and services.
- The care market faces a continuing challenge to recruit and retain sufficient staff to meet demand both in the community and for hospital discharge.
- Challenges in the availability of onward supported accommodation capacity for adult, older people, dementia, and rehab patients with mental health related conditions.

What we have been doing

- December 2022 restart of length of stay reviews for longest waits.
- Zero tolerance to bedding of same day emergency care areas from December 2023
- Gap analysis on processes and understanding of discharge and pathways at ward level January to March 2023
- April 2023 move to protect clinical decision unit for use only by the Emergency department.
- April 2023 Created a new Discharge Lounge at Eastbourne DGH and prevented bedding of lounge at Conquest Hospital.
- May 2023 Full audit of all patients not meeting criteria to reside (NCTR) on both acute sites with support of clinical team from the national Emergency Care Intensive Support Team.
- Development of full back to basics for discharge training programme – commenced delivery to Train the Trainer for all wards May to June 2023
- Revision of on call training support to support on call teams with best practice for patient flow.
- Review of oversight and management arrangements for discharge – new discharge lead May 2023 and improvement plan development April onwards
- Joint work between Trust managed UCR and ASC to allow patients to be supported home prior to ASC picking up so reducing length of stay.

Our Approach

East Sussex system partners have undertaken a significant amount of modelling to understand the demand and capacity for different parts of the system. Much of the data has been derived from tracking discharge hub activity and reviewing unmet community demand both within the NHS and local authority.

Demand Assumptions

- Underpinned by Trust Discharge Sitreps for 2022/23 for four core providers, providing analysis by Pathway.
- Growth 2022/23 to 2023/24: net neutral
- Phased by month by days in month with limited adjustments for seasonal variation.
- Pan Sussex assessment that 2% of Pathway 0 activity requires Social Support
- A limited amount of Pathway 3 activity transferred to Pathway 1 – Domiciliary care – in line with pan Sussex agreed focus on ‘Home First’ and evidence from East Sussex service leads.
- Analysis by ‘sub pathway’ (%) derived from review of patterns of referral 2021/22 and 2022/23; this analysis will be subject to further development as part of the Discharge Front Runner Programme

Capacity Assumptions

Performance (Utilisation factors) and Care Profiles (length of stay and resource use) derived from:

- Routinely produced performance dashboards for Pathway 2 and Pathway 3 services (Pathway 3 care profiles feature length of stay in line with pan Sussex strategy)

- Reviews with service managers were also undertaken to validate Pathway 1 services and available data sources.

Significant Demand and Capacity Gaps

- Social Support: capacity exceeds demand to meet periodic fluctuations – optimisation of Pathway 0 to be addressed via pan Sussex 'Home First' strategy.
- Short term domiciliary care: capacity currently exceeds demand; the plan has been modelled to match demand as patients transferred from Pathway 3 (see note above) as part of discharge transformation plans.
- Rehabilitation at Home: capacity shown exceed demand, this allows for the number of Pathway 1 patients requiring multiple services (based on review of service use 2021/22)
- Rehabilitation in a bedded setting: demand exceeds capacity as some Pathway 2 patients will require bespoke capacity provision due to complex/End of Life Care (EOLC)/All Age Continuing Care needs but is also reflective of known shortfall in the system evidenced by waiting lists for these facilities together with unmet demand from the community. This is a focus of Discharge transformation within the Discharge Front Runner programme.
- Pathway 3 capacity meets current demand assuming the 'Home First' strategy is mobilised and supported by additional assessment capacity.

How East Sussex HWB is using the Better Care Fund to provide the right care in the right place at the right time.

The transformation programme, service redesign schemes and developments are significantly wider than those funded by the Better Care Fund however the BCF plans for 2023-25 seek to provide the right care in the right place at the right time through:

1. Continue to integrate health and social care services and work with our Primary Care Networks to embed proactive care, and seamless wrap around care to people with long term care needs and conditions and those in care homes.
    - Frailty services
    - Carers Services
    - Health and Social Care Connect (Single point of Access)
    - Housing support and adaptations
    - Maintaining social care services
    - Community Equipment services

2. Improve support for people with urgent care needs including targeted support for vulnerable people – by way of admission avoidance and supporting hospital discharge pathways:
    - Community based Intermediate Care and Reablement, by way of both domiciliary and bed-based care and support.
    - Urgent Community Response services
    - Hospital Intervention team based in A&E
    - Discharge to Assess - bed-based capacity.

- Domiciliary Care capacity
- Hospital discharge support provided by the Red Cross.
- 24/7 Health and Social Care Connect (Single point of Access)

These BCF schemes support the delivery of the BCF metrics with many of these schemes being jointly commissioned and jointly provided by Adult Social Care and local NHS Trusts. The schemes support the development of integrated local service delivery and the move towards planning and designing services around local communities as a cornerstone of our vision for integrating care and support.

A commitment from operational teams to collaborate and improve services by taking a whole system approach, reviewing pathways and processes to identify barriers and improve patient journeys, examples of this include:

- Developing direct referral pathways from hospital discharge teams into housing adaptations teams (on occasions using the District and Boroughs powers under their RRO Housing Assistance policy) to provide swift adaptations to enable safe and timely discharge.
- Prioritisation of hospital discharge referrals
- Attendance of housing teams at hospital multi-disciplinary meetings where the discharge is complex and potential housing issues are identified to improve outcomes and system flow.

Our progress in implementing the High Impact Change Model for managing transfers of care.

East Sussex system partners recognise and agree the impact and importance of system flow on patient experience, quality and safeguarding, costs and efficiencies and elective care recovery. The Sussex ICS approach is aligned to our strategic system wide work that incorporates a whole system approach across improved efficiency, admission avoidance, hospital discharges, developing enhanced community responses and growing our virtual wards.

This has patient experience and outcomes at the heart of our work and has been informed by quality and equality impact assessments, the high impact change actions along with hospital flow and discharge pathways as part of the Discharge Front Runner programme.

East Sussex Healthcare NHS Trust, supported by the Emergency Care Intensive Support Unit have reviewed patient flow and identified actions aligned to the High Impact Change Model along with other plans outlined in the East Sussex BCF Plans.

Impact Change	**East Sussex Actions**
Early Discharge Planning	Review Ward and Board round processes, moving from sequential of patient actions, to actions in parallel.
Monitoring and responding to system demand and capacity	Ongoing review of bottlenecks.
Multi-Disciplinary Working	Build on “Frailty Ward” to develop short stay frailty unit with enhanced therapy input.

	Review use of Therapy resources with a more proactive approach
Home First /Discharge to Assess	Work with discharge hub to ensure better feedback and further optimising all pathways.
Flexible Working Patterns	Improve Weekend and Monday discharges, Improved use of discharge lounge
Trusted Assessment	Identifying and implementing Trusted Assessor opportunities
Engagement and Choice	Continued implementation of the new system Choice Policy based upon best practice
Improved Discharge to Care Homes	Increased capacity within Discharge to Assess pathways for bed-based capacity.
Housing and Related Services	Understand and act on current delays for equipment and adaptations

BCF schemes supporting improvements in hospital discharge pathways.

Housing adaptations have been utilised to enable residents to be discharged to usual place of residence via the use of discretionary policies to support with fast tracking works, developing pathways with hospital discharge teams to enable hospital discharge referrals to be prioritised and, where the existing place of residence is not suitable for adaptations, support with options for identifying and relocating to alternative accommodation.

Assisted Discharge Service provided by British Red Cross with additional capacity through the Discharge funding.

Introduction of Personal Health Grant to provide low level support which facilitates hospital discharge.

Community based Intermediate Care and Reablement, by way of both domiciliary and bed-based care and support.

Increased capacity within Discharge to Assess for both Domiciliary Care and bed-based capacity.

How East Sussex HWB have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered

Through services funded via the BCF, we work closely with local VCSE organisations to support everyone to be able to access:

- Clear advice on staying well.
- A range of preventative services
- Simple, joined up care and treatment when this is needed.
- Digital services (with non-digital alternatives) that put the citizen at the heart of their own care.
- Proactive support that keeps people as well as possible, where they are vulnerable or at high risk.

These BCF funded services in East Sussex include community hubs, community connectors, benefits advice, and access to community-based support for people with sensory and mental health needs.
In East Sussex, much of the BCF funding is used to provide services which support the delivery of duties under the Care Act:

Health and Social Care Connect (HSCC) is the East Sussex Single Point of Access to community services and also provides a single point for internal staff and external partners to raise safeguarding concerns.

Support for unpaid carers including young carers, carers who are working and older age carers - further details can be found in the next section.

7. Supporting unpaid carers:

Through the BCF, a wide range of services are jointly funded and commissioned to support unpaid carers including:

Carers Centre provided by Care for the Carers to:

- Raise awareness with service providers & within communities to identify & reach carers
- Information & advice
- Targeted support both to assist with accessing appropriate support for carers & cared for and for carers' own emotional and physical wellbeing.
- Act as "one stop shop" with referral pathways to a range of carers' services
- Provide a range of universal services provided directly by Care for the Carers and commissioned through small grants*
- Provide peer support, carer engagement, wellbeing support and training, Carers Card (contingency planning and discounts)
- Targeted services including one to one casework and emotional support, counselling, Health Care Appointments Respite Grant,
- Targeted support for carers of people with severe mental illness and for young adult carers
- Working with Primary Care practices in the most deprived areas of Hastings and the Havens to reach carers with the most complex needs/caring roles.
- Undertaking carers' reviews on behalf of ASC
- New NHS funded services for 23/24 – the Havens (above) plus carer identification, awareness, and direct support in the acute trust to assist with hospital discharge.

Outcomes for unpaid carers:

- Carers identified early in caring role.
- Reduction in carers reaching crisis point.
- Carers referred to Single Access Point
- Carers recognised as expert partners in care through the health and social care systems.
- Increase in carer friendly communities.
- Identification of carers from communities that are hard to engage, those who have additional vulnerabilities and those at key transition points.
- Carers recognise themselves as carers and are enabled to access the information, advice and support that they need.
- Carers have access to information and advice in a range of formats including by phone and online.
- Carers are signposted/referred on and/or provided with appropriate support/services.
- Carers are supported and enabled to find their own solutions without the need for ongoing support.
- Single referral route for both carer and professional referrals
- Carers can access peer support e.g., through groups or online fora.
- Carers have access to engagement opportunities such as consultation.
- Carers have access to health and wellbeing opportunities.
- Carers can access universal services which reduce the need for access to targeted services

- Carers can access emotional and practical support including face to face, counselling, short-term and crisis interventions that enable carers to look after their own health and wellbeing and sustain their caring role.
- Carers can access training, e.g., condition specific, building resilience, stress management and digital inclusion that will inform their caring role and enable them to care without negatively impacting on their own health and wellbeing.
- Services are inclusive of carers caring at end of life and experiencing bereavement; carers from communities that are hard to engage; those who have additional vulnerabilities and those at key transition points.
- Improved outcomes for carers in primary care
- Evening support group and targets mental health support group reach working age carers.

Care Act services

- Carers Personal Budgets – direct payments to carers to meet Care Act eligible outcomes following a carers assessment or review.
- Carers Reviews Pilot – carers' reviews allocated to Care for the Carer to undertake on behalf of ASC.
- Funded Respite for ASC clients to give carers a break.
- Volunteer Respite services - short home-based breaks (sitting service) where the cared for person is at risk if left alone.
- Carers Break and Engagement Service – undertake carers assessments and reviews for carers of people living with dementia in addition to the NHS funded Dementia Support Service
- Young Carers – a separately commissioned service to provide young carers assessments, individual and family support, workshops and in-school support groups which seek to reduce levels of inappropriate caring and their social, emotional, health and educational needs.

Small Grants (funding now held and allocated by Care for the Carers)

A range of grant funded services including:

- Carer support at all 3 hospices
- Outreach to identify & support BAME carers in Hastings & Eastbourne
- Dementia training
- Digital inclusion
- Short breaks – lunch/supper clubs, creative & social activities, cookery
- Targeted support – Motor Neurone Disease, parent carers of young people with SEND (16-25)
- WRAP (Wellness Recovery Action Planning)

8. Disabled Facilities Grant (DFG) and wider services:

The 2019/20 Annual Report of the Director of Public Health focuses on Health and Housing in East Sussex. Annual Public Health Report 2019/20 - Health and Housing | East Sussex: Joint Strategic Needs Assessment (eastsussexjsna.org.uk) This included the following statements of intent considering opportunities to improve housing in East Sussex.

- **TO MAKE ALL HOUSING AND NEIGHBOURHOODS HEALTHY**: East Sussex County Council and the District and Borough Councils will work more collaboratively on each of the Local Plans through the existing groups - Local Plan Managers and the East Sussex Housing Partnerships Board , sharing data and intelligence to fully understand housing needs and population distribution and hardwiring the principles of "Putting health into place" to ensure health is central to place making, and the design and delivery of homes and neighbourhoods.
- **TO MAKE ALL HOMES HEALTHY**: East Sussex County Council, the District and Borough Councils and the NHS will support and promote initiatives that improve the health and safety of homes, including adaptations that improve environmental sustainability, and promote independent living.
- **TO MAKE PEOPLE HEALTHIER IN THEIR HOMES**: East Sussex County Council, the District and Borough Councils, the NHS and the voluntary and community sector in East Sussex will collaborate to integrate the planning and delivery of care and support in housing, ensuring that specific homelessness and rough sleeping support is continued.

Healthy lives, healthy people: East Sussex Health and Wellbeing Board Strategy | East Sussex County Council sets out the overarching vision supporting the residents of East Sussex and highlights the importance of high-quality safe housing and its impact on health and wellbeing

Whilst the DFG funding is passed down in its entirety, deployment of the DFG funding within the BCF is overseen by the East Sussex Housing Partnerships Board with representation from East Sussex County Council and the Housing departments within local District and Borough Councils as well as health commissioners and wider housing sector partners.

The East Sussex Housing Partnerships Board provides a countywide strategic approach to housing and support issues and oversees effective use of the funding available, including use of adaptations to support independent living and any cross-county projects.

Secondment of specialist Adult Social Care Occupational therapy housing teams into District and Borough Councils in 2019 has allowed for provision of integrated, co-located housing related services including housing adaptations and a move away from the more traditional non-integrated two-tier approach that was previously employed in East Sussex.

This joining up at an operational level as recommended in the DFG review 2018 has enabled a single point of referral, simplification and speeding up of the client journey and an increase in the number of major and minor adaptations, where adaptations are not possible the Occupational Therapist can assist with exploring options available to them and advise about the most appropriate housing solution to meet their needs.

The team use prevention and personalisation to reduce health inequalities, supporting people to live as independently as possible through a greater focus on outcomes and the wider determinants of health in our community, and enabling more people to access more adaptations at the right time for them.

Five unqualified OT staff have received training to enable them to carry out a Trusted Assessor role allowing the assessment and recommendation from simple DFG adaptations such as stairlifts and level access showers, enabling qualified OT staff to focus on the more complex assessments.

Referral routes have been streamlined and are accepted from a wide variety of sources, preventing delays in accessing services, consistency of approaches across areas provides greater equality. Closer working between organisations has meant more timely access to the service and an ability to resolve problems as they occur and with minimal impact on the tenants.

Referrals are screened and triaged based upon a priority and those where risks are highest or requiring support to be discharged are prioritised.

The team can access the full suite of Adult Social Care support by completing Care Act Assessments and are trained in assessing equipment, adaptations, telecare, carers assessments, mental capacity, and safeguarding, they can provide daily living equipment and minor adaptations via the local Integrated Community Equipment service.

They work collaboratively with colleagues from Social Care, Wheelchair services, Health, Voluntary and Housing sectors to consider options to meet individuals' needs.

An innovative example is accessing funds for a 'third party top-up' towards a wheelchair provided by the wheelchair services to enable an additional rise and fall element to be fitted to the seat of the chair, allowing the individual to access higher shelves within their kitchen but also assisting them to access shelves within their local supermarket and have conversations at eye level.

Support is provided with rehousing; either via accessing discretionary assistance to finance moving costs, part-buy schemes to purchase an adaptable property (recently cited as an example of Best Practice by Foundations) or local housing registers. Options are fully explained and referrals to organisations such as Brighton Housing trust or internal Housing Solutions workers made. Assessments of temporary accommodation and adaptations and equipment in alternative housing are also carried out. Interim risk management measures are also provided.

Assessments are undertaken for individuals regardless of whether they live in public or private sector housing. For individuals who are identified as self-funding adaptations are offered information and advice to ensure their needs are appropriately met.

This service has successfully won the DFG team of the year award by Foundations in 2022.

The following services have been or are in the process of being developed to use housing support, including DFG funding, to support independence at home:

- Integration and co-location of Housing OT Service into DFG teams
- Review and updating of discretionary DFG policies, using the joint strategic needs assessments to identify gaps in service provision and focus on place-based provision of

services tailored to the needs of the specific communities within district or borough areas aiming to address health inequalities.
- Development and adaptation of temporary accommodation that supports independence for users who are disabled.
- Working with housing development teams to ensure requirements for accessible and adaptable new build housing is tailored to the needs of the local population and addresses current shortfalls.

In addition to BCF funded Housing support there are a range of other Housing Support services across East Sussex including:

- Extra-care facilities
- Shared lives/ Supported accommodation: a number of planned developments for supported living and potential shared lives placements over the next 3 years.
- Floating support services
- Homelessness and Rough Sleeper initiatives
- Telecare and Telecheck services
- Warm homes teams
- Mental health services links with housing
- ESCC pilot of assistive technology (Alexa)
- Linked smoke alarms, jointly funded with East Sussex Fire and Rescue services

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? **Yes**

The amount allocated for these discretionary uses is £4,061,806 per annum. Further information can be found at:

Disabled Facilities Grants in Hastings

Eastbourne Housing Strategy 2020-2024 - Lewes and Eastbourne Councils (lewes-eastbourne.gov.uk)

Housing Financial Assistance Policy 2021-2025 – Rother District Council

Discretionary Assistance for Disabled Occupants - Wealden District Council - Wealden District Council

9. Equality and health inequalities

The East Sussex partners continue to work together guided by the council's priorities under the Equality Act, NHS equalities duties and the NHS Core20PLUS5 approach to reducing healthcare inequalities.

We'll build on our existing progress to:

- empower people to stay healthy and well for as long as possible.
- reduce health inequalities and the gap in life expectancy and healthy life expectancy in the county.

We will do this by working with all the services that influence health, like housing, employment and leisure as described in the wider determinants of health section. We believe that collectively our organisations can make a real difference to our population's economic and social wellbeing.

East Sussex is a county with a growing and ageing population. By 2026, almost one in four people here (24%) will be aged 65 to 84. For England as a whole, that figure is nearer one in six (17%). More than 4% of our population will be over 85. This compares to less than 3% for England as a whole.

With more older people, which includes those who are frail and have multiple conditions, East Sussex is likely to have higher health and care needs than other areas of our size. This rise in demand is just one part of our health and care for the whole population.

By 2028, around 20,000 more people in East Sussex will be living with two or more long-term health conditions than was the case a decade earlier.

The number of children in need of help and protection is rising locally and nationally, linked to the increase in families with financial difficulties. There is also a rise in the number of children with statements of special educational needs and disability (SEND), some of whom will have complex medical and care needs.

East Sussex is both rural and urban, which brings challenges in ensuring the right access to services and at the right quality. Our coastal communities reflect the patterns of inequality and poverty highlighted nationally in the Chief Medical Officer's report from 2021 and there is also hidden poverty in our rural areas.

On average, our population's health is similar to England's but there are wide variations within East Sussex. People in deprived areas tend to be affected by poorer health. The gap in life expectancy between our most and least-deprived areas is more than 11 years for men and almost 10 years for women.

A person's chance of enjoying good health and a longer life is influenced by the social and economic conditions in which they are born, grow, work, live and age. These affect the way people look after their own health and use services throughout their life. The poorer your circumstances, the more likely you are to have poor health and wellbeing, spend more of your days with life-limiting illness and die prematurely. This requires joining up NHS and social care with other services provided by the County Council, district, and borough councils, the voluntary, community and social enterprise sector and other services and businesses that affect people's lives, health, and social or economic wellbeing.

The Covid-19 pandemic also further highlighted how a combination of structural inequalities in our society (for example, income and housing) and inequalities experienced due to ethnic background and other characteristics, led to increased risks for some groups.

We want to reduce health inequalities for our population. This will be measured by inequality in healthy life expectancy at birth. It will require us to work differently on how resources are used, how we assess the impact of the decisions we make and look at new ways in which everyone can have equal access to appropriate services. This includes identifying where some groups may require more intensive support and additional help to access services. Health and care also needs to be delivered with an awareness of the differences between groups and within our population and tailored to each individual's strengths and potential vulnerabilities. Every opportunity will be explored to make sure we improve our ability to do this.

We are monitoring our progress with delivery of our priorities across the four areas below to make sure we are having the most impact:

Addressing the causes of ill health to prevent premature death and the overall prevalence of disease. The Core20Plus5 approach sets out a model to support integrated care systems to focus on health inequalities by identifying local areas of focus linked to deprivation and outlining the 5 key clinical areas for health inequalities:

- early cancer diagnosis
- chronic respiratory disease
- hypertension case finding to minimise risks of heart attacks and strokes.
- continuity of maternity care
- annual health checks for people living with serious mental illness and learning disabilities.

We will also focus on identified and prioritised population groups that are experiencing health inequality and disadvantage. In East Sussex these are identified as:

- Carers.

- LGBTQ+ groups

One overarching recommendation is that the East Sussex Health and Care system prioritises the improvement recording and monitoring of protected characteristics. Although Carers are not a protected group under legislation, it is recommended that within the East Sussex health and care system that they are treated in this way. In terms of making change – there are two approaches – top down- SROs for Health inequalities champion the importance of data recording and monitoring within their organisation; and practically - to link up with the ICS programme to improve ethnicity recording and include LGBTQ+ and carers at the same time when reviewing data systems and considering staff training.

We will prioritise the improvement of healthy life expectancy tackling the key health inequality related conditions and ill health through:

- Supporting individuals and populations to adopt healthy behaviours, including promoting and supporting healthy weight, and action to reduce harm from alcohol and tobacco.
- Addressing the social and emotional factors that influence health in our communities, including the economic wellbeing of our population.

- Further developing our capability as a system, including through locality and neighbourhood working and a 'Population Health Management' approach. This is a way of working supported by data and insight, to help frontline teams understand current health and care needs and what factors are driving poor outcomes in different population groups. This will result in more proactive models of care which will improve health and wellbeing today and in future years.

The BCF in East Sussex funds a wide range of services provided by the VCSE sector. These services include community hubs, community connectors, benefits advice, and access to community-based support for people with sensory and mental health needs.

The East Sussex BCF schemes are subject to the requirements of the commissioning partner organisations in respect of Equality Impact Assessments. Consideration is given to the level of the schemes' impacts on the wider determinants of health and Core20+5 priorities to reduce health inequalities.

The East Sussex BCF is embedded in the local health and social care economy and broader plans and as with wider health and care, services funded via the BCF need to ensure they are accessible for people with protected characteristics and / or experience health inequalities.

To support shared accountability for delivering the vision and the outcomes, our Health and Wellbeing Board has brought together a small number of strategic outcomes that we all share and have agreed we will work together to measure and improve. We are continuing to make sure that these align with our developing ICS strategy and framework.

The outcomes are based on what local people have told us is important about their health and care services and other areas. These have been used to inform this strategy as well as our East Sussex Health and Care Plan and programme and the other strategies and plans that will support delivery of this strategy.

Outcomes are set out under four headings:

- Population health and wellbeing
- The experience of care
- The quality of care
- Transforming services for sustainability

As we develop at place into 2023-24 and beyond, any review and restructuring of our BCF programme, including new schemes, will require new or refreshed Equality Impact Assessments.

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BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme

- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	East Sussex
Completed by:	Sally Reed
E-mail:	sally.reed@eastsussex.gov.uk
Contact number:	01273 481912
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no please indicate when the HWB is expected to sign off the plan:	

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Keith	Glazier	cllr.keith.glazier@eastsussex.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Adam	Doyle	adam.doyle5@nhs.net
	Additional ICB(s) contacts if relevant		Jessica	Britton	jessica.britton@nhs.net

Local Authority Chief Executive		Becky	Shaw	becky.shaw@eastsussex.gov.uk
Local Authority Director of Adult Social Services (or equivalent)		Mark	Stainton	mark.stainton@eastsussex.gov.uk
Better Care Fund Lead Official		Sally	Reed	sally.reed@eastsussex.gov.uk
LA Section 151 Officer		Ian	Gutsell	ian.gutsell@eastsussex.gov.uk

Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: East Sussex

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£8,123,612	£8,123,612	£8,123,612	£8,123,612	£0
Minimum NHS Contribution	£49,618,443	£52,426,847	£49,618,443	£52,426,847	£0
iBCF	£21,776,611	£21,776,611	£21,776,611	£21,776,611	£0
Additional LA Contribution	£694,000	£694,000	£694,000	£694,000	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£3,053,047	£5,068,058	£3,053,047	£5,068,058	£0
ICB Discharge Funding	£3,537,522	£5,024,117	£3,537,522	£5,024,117	£0
Total	**£86,803,235**	**£93,113,245**	**£86,803,235**	**£93,113,245**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£14,100,155	£14,898,223
Planned spend	£16,617,472	£17,368,750

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£24,694,953	£26,092,688
Planned spend	£25,428,801	£26,457,365

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	180.8	140.3	172.7	173.3

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,200.7	2,134.6
	Count	3379	3278
	Population	143415	143415

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan

Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	91.7%	92.8%	93.0%	94.0%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	494	450

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes

	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: East Sussex

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	Please see narrative for detail

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!! | Demand - Hospital Discharge

Trust Referral Source (Select as many as you need)	Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
EAST SUSSEX HEALTHCARE NHS TRUST	Social support (including VCS) (pathway 0)	40	41	40	41	41	40	41	40	41	41	38	41
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST		1	1	1	1	1	1	1	1	1	1	1	1
SURREY AND SUSSEX HEALTHCARE NHS TRUST		0	0	0	0	0	0	0	0	0	0	0	0
UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST		16	17	16	17	17	16	17	16	17	17	16	17
EAST SUSSEX HEALTHCARE NHS TRUST	Reablement at home (pathway 1)	34	35	34	35	35	34	35	34	35	35	32	35
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST		1	1	1	1	1	1	1	1	1	1	1	1
SURREY AND SUSSEX HEALTHCARE NHS TRUST		0	0	0	0	0	0	0	0	0	0	0	0
UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST		12	12	12	12	12	12	12	12	12	12	11	12
EAST SUSSEX HEALTHCARE NHS TRUST	Rehabilitation at home (pathway 1)	84	86	84	86	86	84	86	84	86	86	81	86
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST		1	1	1	1	1	1	1	1	1	1	1	1
SURREY AND SUSSEX HEALTHCARE NHS TRUST		1	1	1	1	1	1	1	1	1	1	1	1
UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST		29	30	29	30	30	29	30	29	30	30	29	30
EAST SUSSEX HEALTHCARE NHS TRUST	Short term domiciliary care (pathway 1)	67	70	67	70	70	67	70	67	70	70	66	70
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST		1	1	1	1	1	1	1	1	1	1	1	1
SURREY AND SUSSEX HEALTHCARE NHS TRUST		0	0	0	0	0	0	0	0	0	0	0	0
UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST		20	21	20	21	21	20	21	20	21	21	20	21
EAST SUSSEX HEALTHCARE NHS TRUST	Reablement in a bedded setting (pathway 2)	20	20	20	20	20	20	20	20	20	20	19	20
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST		1	1	1	1	1	1	1	1	1	1	1	1
SURREY AND SUSSEX HEALTHCARE NHS TRUST		0	0	0	0	0	0	0	0	0	0	0	0
UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST		7	8	7	8	8	7	8	7	8	8	7	8
EAST SUSSEX HEALTHCARE NHS TRUST	Rehabilitation in a bedded setting (pathway 2)	100	104	100	104	104	100	104	100	104	104	97	104
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST		3	3	3	3	3	3	3	3	3	3	2	3
SURREY AND SUSSEX HEALTHCARE NHS TRUST		1	1	1	1	1	1	1	1	1	1	1	1
UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST		38	39	38	39	39	38	39	38	39	39	37	39
EAST SUSSEX HEALTHCARE NHS TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home	69	70	69	70	70	69	70	69	70	70	66	70
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	placement (pathway 3)	1	1	1	1	1	1	1	1	1	1	1	1
SURREY AND SUSSEX HEALTHCARE NHS TRUST		0	0	0	0	0	0	0	0	0	0	0	0
UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST		12	12	12	12	12	12	12	12	12	12	11	12

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	597	617	597	617	617	597	617	597	617	617	577	617
Urgent Community Response	1317	1361	1317	1361	1361	1317	1361	1317	1361	1361	1273	1361
Reablement at home	89	89	89	89	89	89	89	89	89	89	89	89
Rehabilitation at home	457	457	457	457	457	457	457	457	457	457	457	457
Reablement in a bedded setting	11	11	11	11	11	11	11	11	11	11	11	11
Rehabilitation in a bedded setting	8	8	8	8	8	8	8	8	8	8	8	8
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	100	100	100	100	100	100	100	100	100	100	100	100			100%
Reablement at Home	Monthly capacity. Number of new clients.	48	48	48	48	48	48	48	48	48	48	48	48		100%	
Rehabilitation at home	Monthly capacity. Number of new clients.	246	246	246	246	246	246	246	246	246	246	246	246	100%		
Short term domiciliary care	Monthly capacity. Number of new clients.	87	87	87	87	87	87	87	87	87	87	87	87	100%		
Reablement in a bedded setting	Monthly capacity. Number of new clients.	23	23	23	23	23	23	23	23	23	23	23	23			100%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	115	115	115	115	115	115	115	115	115	115	115	115	100%		
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	83	83	83	83	83	83	83	83	83	83	83	83	100%		

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	597	617	597	617	617	597	617	597	617	617	577	617			100%
Urgent Community Response	Monthly capacity. Number of new clients.	1317	1361	1317	1361	1361	1317	1361	1317	1361	1361	1273	1361	100%		
Reablement at Home	Monthly capacity. Number of new clients.	89	89	89	89	89	89	89	89	89	89	89	89		100%	
Rehabilitation at home	Monthly capacity. Number of new clients.	457	457	457	457	457	457	457	457	457	457	457	457	100%		
Reablement in a bedded setting	Monthly capacity. Number of new clients.	11	11	11	11	11	11	11	11	11	11	11	11			100%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	4	4	4	4	4	4	4	4	4	4	4	4	100%		
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			100%

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: East Sussex

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
East Sussex	£8,123,612	£8,123,612
DFG breakdown for two-tier areas only (where applicable)		
Eastbourne	£1,755,225	£1,755,225
Hastings	£2,056,655	£2,056,655
Lewes	£1,225,885	£1,225,885
Rother	£1,844,806	£1,844,806
Wealden	£1,241,041	£1,241,041
Total Minimum LA Contribution (exc iBCF)	**£8,123,612**	**£8,123,612**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
East Sussex	£3,053,047	£5,068,058

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS Sussex ICB	£3,537,522	£5,024,117

Total ICB Discharge Fund Contribution	£3,537,522	£5,024,117

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
East Sussex	£21,776,611	£21,776,611
Total iBCF Contribution	**£21,776,611**	**£21,776,611**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
East Sussex	£694,000	£694,000	Carers Services
Total Additional Local Authority Contribution	**£694,000**	**£694,000**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Sussex ICB	£49,618,443	£52,426,847
Total NHS Minimum Contribution	**£49,618,443**	**£52,426,847**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	No

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	**£0**	
Total NHS Contribution	**£49,618,443**	**£52,426,847**	

	2023-24	2024-25
Total BCF Pooled Budget	**£86,803,235**	**£93,113,245**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: East Sussex

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£8,123,612	£8,123,612	£0	£8,123,612	£8,123,612	£0
Minimum NHS Contribution	£49,618,443	£49,618,443	£0	£52,426,847	£52,426,847	£0
iBCF	£21,776,611	£21,776,611	£0	£21,776,611	£21,776,611	£0
Additional LA Contribution	£694,000	£694,000	£0	£694,000	£694,000	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£3,053,047	£3,053,047	£0	£5,068,058	£5,068,058	£0
ICB Discharge Funding	£3,537,522	£3,537,522		£5,024,117	£5,024,117	£0
Total	**£86,803,235**	**£86,803,235**	**£0**	**£93,113,245**	**£93,113,245**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£14,100,155	£16,617,472	£0	£14,898,223	£17,368,750	£0
Adult Social Care services spend from the minimum ICB allocations	£24,694,953	£25,428,801	£0	£26,092,688	£26,457,365	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

>> Incomplete fields on row number(s):

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Planned Expenditure: Area of Spend	Planned Expenditure: Please specify if 'Area of Spend' is 'other'	Planned Expenditure: Commissioner	Planned Expenditure: % NHS (if Joint Commissioner)	Planned Expenditure: % LA (if Joint Commissioner)	Planned Expenditure: Provider	Planned Expenditure: Source of Funding	Planned Expenditure: New/ Existing Scheme	Planned Expenditure: Expenditure 23/24 (£)	Planned Expenditure: Expenditure 24/25 (£)	Planned Expenditure: % of Overall Spend (Average)
1	Protecting ASC services which benefit health	A range of social care services which benefit health	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£6,936,579	£6,936,579	9%
2	Protecting ASC services which support hosptial	A range of social care services to support hospital discharge	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£5,386,547	£5,386,547	7%
3	Protecting ASC services in line with iBCF criteria	A range of social care services to meet iBCF criteria	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	iBCF	Existing	£21,776,611	£21,776,611	27%
4	Milton Grange - Community Bed Based	ESCC provision of Intermediate Care beds in Eastbourne	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step		149	149	Number of Placements	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,683,500	£1,683,500	47%
4	Milton Grange - Community Bed Based	ESCC provision of Intermediate Care beds in Eastbourne	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step		149	149	Number of Placements	Community Health		LA			Local Authority	Minimum NHS Contribution	Existing	£1,683,500	£1,683,500	47%
5	Community Bed Based Intermediate Care	Funding towards Independent Sector Commissioned Intermediate	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		10	10	Number of Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£89,000	£89,000	3%
5	Community Bed Based Intermediate Care	Funding towards Independent Sector Commissioned Intermediate	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		10	10	Number of Placements	Community Health		LA			Private Sector	Minimum NHS Contribution	Existing	£89,000	£89,000	3%
6	Joint Community Rehabilitation Services	Funding to support provision of 7 day service	Home-based intermediate care services	Joint reablement and rehabilitation service (accepting step up and step		77	77	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£433,500	£433,500	22%
6	Joint Community Rehabilitation Services	Funding to support provision of 7 day service	Home-based intermediate care services	Joint reablement and rehabilitation service (accepting step up and step		155	155	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£433,500	£433,500	22%
7	Carers Servcies	A range of carers support services commissioned by ESCC.	Carers Services	Respite services		6533	6586	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£1,982,153	£1,982,153	46%
7	Carers Services	A range of carers support services commissioned by ESCC.	Carers Services	Respite services		61	61	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£22,000	£22,000	1%

7	Carers Services	A range of carers support services commissioned by ESCC.	Carers Services	Respite services		10	10	Beneficiaries	Community Health		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£4,000	£4,000	1%
8	Carers Services	A range of carers support services commissioned by ESCC.	Carers Services	Carer advice and support related to Care Act duties		12765	13344	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£1,463,355	£1,463,355	34%
8	Carers Services	A range of carers support services commissioned by ESCC.	Carers Services	Carer advice and support related to Care Act duties		2492	2671	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£672,000	£672,000	16%
9	Disabled Facilities Grant	DFG and housing support services	DFG Related Schemes	Adaptations, including statutory DFG grants		1367	1367	Number of adaptations funded/people	Other	Adaptations, including statutory DFG	LA			Local Authority	DFG	Existing	£4,061,806	£4,061,806	50%
10	Disabled Facilities Grant	DFG and housing support services	DFG Related Schemes	Discretionary use of DFG		600	600	Number of adaptations funded/people	Other	Discretionary use of DFG	LA			Local Authority	DFG	Existing	£4,061,806	£4,061,806	50%
12	Carers Services	Carers commissioning team	Carers Services	Other	Carers commissioning team	0	0	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£175,100	£175,100	4%
13	Care Act Implementation	Care Act Duties, including info/advice, safeguarding, advocacy and reviewing.	Care Act Implementation Related Duties	Other	Care Act Duties, including info/advice,				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,617,000	£1,617,000	92%
14	Frailty	Multi-discplinary frailty services in HWLH area	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£491,000	£491,000	3%
15	Diabetes	Diabetes Support in HWLH area	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£1,216,000	£1,216,000	8%
16	Lewes UTC	Ad Av pathways	Urgent Community Response						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£474,000	£474,000	100%
17	Intermediate Care Services	Joint Community Rehab servcies in HWLH area	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		4204	4414	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£888,000	£888,000	46%
18	IAPT	Access to Psycholgical Therapies in HWLH	Prevention / Early Intervention	Other	Psycholgical Therapies in HWLH				Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution	Existing	£352,000	£352,000	6%
19	Enhanced Health in Care Homes	Enhanced Health in Care Homes	Personalised Care at Home	Other	Physical health and mental health well-				Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£1,188,000	£1,188,000	8%
20	Enhanced HIT - scheme continuing	Addtional ASC capacity to cover extended hours	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		NHS			Local Authority	Minimum NHS Contribution	Existing	£205,000	£205,000	29%
21	SCT Medicines Optimisation in Care Homes	Medicines Optimisation in Care Homes	Other						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£529,000	£529,000	22%
22	ESHT Community Programme	Additional community services including crisis response, frailty	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£7,809,000	£7,809,000	10%
23	HSCC Overnight Service	Funding for HSCC cover 22.00-08.00hrs	Enablers for Integration	Integrated models of provision					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£132,500	£132,500	6%
23	HSCC Overnight Service	Funding for HSCC cover 22.00-08.00hrs	Enablers for Integration	Integrated models of provision					Community Health		NHS			Local Authority	Minimum NHS Contribution	Existing	£132,500	£132,500	6%
24	Consultant pharmacist in diabetes	Consultant pharmacist in diabetes	Other						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£76,000	£76,000	3%
25	Dieticians in Meds Management team (2)	Dieticians in Meds Management team (2)	Other						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£95,000	£95,000	4%
26	Medicines Optimisation in LD Care Homes	Medicines Optimisation in Care Homes	Other						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£98,000	£98,000	4%
27	Home First Pathway 3	D2A beds	Residential Placements	Short-term residential/nursing care for someone likely to require a					Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£1,103,765	£2,132,329	1%
27	Home First Pathway 3	D2A beds	Residential Placements	Short-term residential/nursing care for someone likely to require a					Community Health		LA			Private Sector	Minimum NHS Contribution	Existing	£1,103,766	£2,132,328	1%
28	Staff - Programme and Project support	A range of joint posts	Other						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£786,721	£786,721	33%
28	Staff - Programme and Project support	A range of joint posts	Other						Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£277,475	£277,475	12%

29	Health and Social Care Connect	Funding for health hub within HSCC (Single Point of Access)	Enablers for Integration	Integrated models of provision					Community Health		NHS			Local Authority	Minimum NHS Contribution	Existing	£630,000	£630,000	29%
30	High Intensity User Service	High Intensity Users - case management	Personalised Care at Home	Mental health /wellbeing					Community Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution	Existing	£181,000	£181,000	1%
31	ICES Pooled Budget	NHS contribution to Community Equipment Pooled budget	Assistive Technologies and Equipment	Community based equipment		122992	129142	Number of beneficiaries	Community Health		LA			Private Sector	Minimum NHS Contribution	Existing	£2,900,000	£2,900,000	43%
32	VCSE services	NHS contibution to VCSE services commissioned by ESCC.	Prevention / Early Intervention	Other	A range of services provided by				Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£1,892,084	£1,892,084	33%
32	VCS services	NHS contribution to VCS services commissioned by ESCC.	Prevention / Early Intervention	Other	A range of services provided by				Community Health		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£946,042	£946,042	16%
32	VCS servcies	NHS contribution to VCS services commissioned by ESCC.	Prevention / Early Intervention	Other	A range of services provided by				Mental Health		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£946,042	£946,042	16%
33	Healthy Hastings and Rother	VCSE services commissioned by NHS.	Prevention / Early Intervention	Other	A range of services provided by				Community Health		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£862,817	£862,817	15%
34	Domiciliary care capacity	Additional investment in home care provision to support hospital discharge	Home Care or Domiciliary Care	Domiciliary care packages		42540	42540	Hours of care	Social Care		NHS			Private Sector	Minimum NHS Contribution	Existing	£1,418,000	£1,418,000	8%
35	Dementia Post Diagnostic Support Services:	Dementia Post Diagnostic Support Services	Prevention / Early Intervention	Other	Dementia Post Diagnostic Support Services				Mental Health		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£784,000	£784,000	14%
36	BCF Reserve	Contingency for service pressures	Other						Social Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	New	£123,997	£123,997	5%
37	BCF Reserve	Pending uplift and application agreements	Other						Community Health		NHS			NHS	Minimum NHS Contribution	New	£0	£751,278	16%
38	Domiciliary Home care capacity	Additional investment in home care provision to support hospital discharge	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		87108	87108	Hours of care	Social Care		LA			Private Sector	Local Authority Discharge	New	£2,873,047	£2,873,047	16%
39	Weekend Discharge Team	Additional capacity to support hospial discharges at weekends	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Acute		NHS			NHS Acute Provider	ICB Discharge Funding	New	£342,408	£342,408	48%
40	High Intensity Users/Mental Heath Discharge	Discharge Co-ordination	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding	New	£170,004	£170,004	24%
41	Additional ASC assessment	Additional ASC assessment capacity	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge	New	£180,000	£500,000	11%
42	Personal Health Grants	Small grants issued to support hospital discharge	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Social Care		NHS			Charity / Voluntary Sector	ICB Discharge Funding	New	£62,400	£62,400	0%
43	Additional D2A Beds	Additional D2A Beds	Residential Placements	Short-term residential/nursing care for someone likely to require a					Social Care		NHS			Private Sector	ICB Discharge Funding	New	£2,791,194	£3,439,836	2%
44	Assisted Discharge Home - BRC	Home from Hospital support form the British Red Cross	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Social Care		LA			Charity / Voluntary Sector	ICB Discharge Funding	New	£171,516	£171,516	0%
45	Domiciliary Home care capacity	Additional investment in home care provision to support hospital discharge	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		0	922	Hours of care	Social Care		LA			Private Sector	ICB Discharge Funding	New	£0	£837,953	2%
46	Block beds for clients with complex care	Block beds for clients with complex care needs	Residential Placements	Short-term residential/nursing care for someone likely to require a					Social Care		LA			Private Sector	Local Authority Discharge	New	£0	£1,040,000	1%
47	OT in-reach to D2A beds	OT in-reach to D2A beds	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Social Care		LA			Local Authority	Local Authority Discharge	New	£0	£655,011	100%

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: East Sussex

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	183.2	146.2	177.0	134.7	Negligible growth or change in seasonal pattern in non elective activity between 22/23 and 23/24. No significant change in population. 3% Nominal reduction in avoidable admissions each quarter compared with 22/23 activity levels delivered through Sussex wide emerging plans.	The pan Sussex ambition is to maintain improvements seen since Q4 21/22 as the system stabilised following the pandemic. Further improvements are anticipated through schemes targetting specific conditions (under the Ageing Well, Frailty and Long Term Conditions Programmes) and the roll out of the Virtual Wards
	Number of Admissions	1,380	1,101	1,333	-		
	Population	557,229	557,229	557,229	557,229		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	180.8	140.3	172.7	173.3		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,523.4	2,200.7	2,134.6	Negligible anticipated growth in non elective activity between 22/23 and 23/24. No significant change in population. 3% Nominal reduction in 'admissions due to falls' delivered through Sussex wide emerging plans and East Sussex specific initiatives.	Improvements are anticipated through: 'Enhanced Care in East Susex Care Homes' schemes focussing on falls prevention; equipping East Sussex UCR teams to respond to new 111/999 Falls pathway in conjunction with the Sussex wide roll out of an Admission Avoidance SPOA; re-energising the Consultant Geriatricians
	Count	3,880	3,379	3,278		
	Population	143,415	143,415	143,415		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
	Quarter (%)	91.4%	92.4%	91.6%	91.4%	Negligible antcipated growth or change in seasonal pattern in non elective activity	Discharge model for Sussex to be finalised during the first half of 23/24 as part of the
	Numerator	10,066	10,014	10,212	9,920		

Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Denominator	11,016	10,832	11,154	10,848	between 22/23 and 23/24. Historic analysis indicates sustained but minor increase in discharges home over time (<0.5%). Mobilisation of Sussex strategy from October 23 to reach 95% target incrementally during 24/25.	Front Runner Programme and mobilised in the second half of the year. This plan will build on proposals developed in 22/23 which were underpinned by detailed analysis of the existing but inconsistent approaches across Sussex places and has an agreed focus on 'Home First'. This will
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Quarter (%)	91.7%	92.8%	93.0%	94.0%		
	Numerator	10,106	10,054	10,370	10,198		
	Denominator	11,016	10,832	11,154	10,848		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	494.2	490.5	461.5	450.4	2022-23 estimated performance is 488.8 (using latest Mid year population estimate of 143,415). 2023-24 plan (using same population figure) is 485.3	Continued investment in Joint Community Rehab and other community based services, maximising opportunitiy for people to remain living in their own homes. Maximising use of seven Extra Care Schemes across the East Sussex, providing
	Numerator	722	745	701	696		
	Denominator	146,088	151,889	151,889	154,515		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	89.7%	90.5%	91.2%	90.0%	Performance has continued to be compartively high, and has consistenly been above a minimum of 88.4% in the last 5 years. Target therefore continues to be greater than or equal to 90%	Continued investment in Joint Community Rehabilitation Service and other community based services to maintain upper quartile performance
	Numerator	288	344	238	235		
	Denominator	321	380	261	261		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

Better Care Fund 2023-25 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: East Sussex

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan	Yes	Planning template - Tab 6a Planning template - Tab 2 Narative Plan - Pages 3-4 N/A Planning template		
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan	Yes	Narrative Plan - pages 26-28 Narrative Plan -pages 8-9 Narrative Plan - page 31 Narrative Plan - pages 29-31 Narrative Plan - pages 29-31		
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan	Yes	Narrative Plan - pages 12-13 Planning template - Tab 6a		
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4**	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan	Yes	Narrative Plan - pages 8-9 Planning template - Tab 6a Narrative Plan - page 9 Planning template - Tab 4 Narrative Plan - pages 13-14, 18-20		

Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans	Yes	Planning template - Tab 6a Planning template - Tab 6a Narrative Plan - page 18 Narrative Plan - pages 20--21 N/A		
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan	Yes	Narrative Plan - page 16-17 Planning template - Tab 6a Narrative Plan - page Planning template - Tab 6a Narrative Plan - pages 16-21 Planning template - Tab 6a Narrative Plan - pages 21-22		
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan	Yes	Planning template - Tab 6a		

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan	Yes	Planning template - Tab 6a Planning template - Tab 6a Planning template - Tab 6a Planning template - Tab 6a Planning template - Tab 6a Narrative Plan - pages 11-12, 24-25 Planning template - Tab 6a		
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan	Yes	Planning template - Tab 6a Planning template - Tab 6a		

Report to:	**East Sussex Health and Wellbeing Board**
Date:	**27 June 2023**
By:	**Director of Public Health**
Title:	**East Sussex Public Health and Planning Memorandum of Understanding (MOU)**
Purpose of Report:	**To inform the Board of the development of a Memorandum of Understanding (MOU) covering the Public Health aspects of planning.**

Recommendations:

East Sussex Health and Wellbeing Board is recommended to:

1) Note the Memorandum of Understanding between the County Council and Borough and District Councils in respect of planning from a Public Health perspective.

1 Background

1.1 Public Health has a role and responsibility to work for all and speak to all parts of the wider systems (enable and facilitate as well as the need to enable, lead and support):

- Health in all policies: a manual for local government | Local Government Association
- District councils' contribution to public health |
- The King's Fund (kingsfund.org.uk)
- The district council contribution to public health (kingsfund.org.uk)
- District councils' role in health and social care (kingsfund.org.uk)

It has the responsibility to 'make health everybody's business' and for health to feature strongly in 'all policies' if we are to create healthy, prosperous and equitable people and places.

1.2 Population health and wellbeing is impacted not only by individual behaviour, but by the wider determinants such as those within the built and natural environment as depicted below.

1.3 Some of the most pressing health challenges such as obesity, mental health issues, physical inactivity, and the needs of an ageing population, can all be influenced by the quality of our built and natural environment. These wider determinants of health are influenced by the planning system and therefore improving both physical and mental health and wellbeing is integral to land use planning. This is through areas such as place-making, design, regeneration, sustainable development, green infrastructure, active and sustainable travel, and development management. The links between health and planning are recognised in the National Planning Policy Framework 2021 (NPPF) and its accompanying Practice Guidance (NPPG).

1.4 It is acknowledged that whilst most of the public health agenda is nothing new for land use planning there is growing policy, guidance, and evidence of the specific links between the two areas and therefore there is now a real opportunity to strengthen how health and wellbeing is addressed within the planning system. This will add value not only to existing work which already considers health impacts and inequalities but will also support work addressing shared objectives with health on tackling the climate change emergency and delivering an economic recovery post Covid 19.

1.5 It is also acknowledged that other health teams and organisations input into the planning system to improve health and wellbeing such as environmental health teams, health and wellbeing teams in district authorities and the National Health Service (NHS). This MOU will support and link in with the work being done by these other partners.

1.6 Purpose of the MOU

The MOU supports delivery of the East Sussex County Council Plan. More specifically:

- Driving sustainable economic growth - Individuals, communities and businesses thrive in East Sussex with the environmental, and social infrastructure to meet their needs.
- Keeping vulnerable people safe - People feel safe at home.
- Helping people help themselves - The most vulnerable get the support they need to maintain their independence, and this is provided at or as close to home as possible.

It also supports delivery of the Sussex Integrated Care Strategy:

- People to live for longer in good health.
- To reduce the gap in healthy life expectancy between people living in the most and least disadvantaged communities.

More specifically its ambitions to:

- Creating healthy environments for children, young people and families to grow up in.
- Supporting people to live, work and play in places that promote health and wellbeing.

1.7 The MOU has been developed between the Council's public health department and Borough and District Council planning officers to build consensus and mutual understanding. It will build consistency across the County in the approach to creating healthy and sustainable places, strengthening compliance to the Duty to Cooperate. It will also be a mechanism which will help to deliver against the East Sussex Health and Wellbeing Strategy, the Creating Healthy and Sustainable Places – A Framework for East Sussex, and Local Plan policy objectives concerning health, wellbeing, and sustainability.

1.8 The Memorandum of Understanding (MOU) sets out how the Public Health Team within East Sussex County Council (ESCC) and Local Planning Authorities (LPAs) will work together to deliver the County Council's statutory public health responsibilities and LPAs duties to deliver relevant elements of the National Planning Policy Framework through the planning system. The MOU includes all LPAs within East Sussex which are Eastbourne Borough Council, East Sussex County Council, Hastings Borough Council, Lewes District Council, Rother District Council, South Downs National Park Authority and Wealden District Council (see Appendix 1).

1.9 The MOU provides the policy context and links between planning and health. It provides an overarching agreement and intention to work together countywide to improve the health and wellbeing of our residents. It sets out the high-level actions that parties will take, including working together to agree specific actions around processes, engagement, and parameters to establish robust working outcomes and objectives. These will be developed into detailed agreements between Public Health and individual LPAs.

2 Links to National Policies and requirements

National Planning Policy Framework, 2021 (NPPF)

2.1 The NPPF requires public health to be considered in both plan-making and decision-taking and states the purpose of planning is to contribute to the achievement of sustainable development, with delivery of the social objective of sustainable development being paramount to supporting health.

2.2 The social objective in paragraph 8b supports strong, vibrant, and healthy communities, by ensuring that a sufficient number and range of homes can be provided to meet the needs of present and future generations; and by fostering well-designed, beautiful, and safe places, with accessible services and open spaces that reflect current and future needs and support communities' health, social and cultural wellbeing.

2.3 Section 8 'Promoting healthy and Safe Communities' paragraph 92, requires planning policies and decisions to aim to achieve healthy, inclusive, and safe places which promote social interaction, that are safe and accessible, and enable and support healthy lifestyles, especially where this would address identified local health and wellbeing needs.

2.4 Paragraph 93 requires planning policies and decisions to provide the social, recreational, and cultural facilities and services the community needs, through planning positively for the provision and use of shared space, community facilities and other local services to enhance the sustainability of communities and residential environments.

2.5 Paragraph 98 recognises the importance of access to a network of high-quality open spaces and opportunities for sport and physical activity for health and wellbeing of communities which can also deliver wider benefits for nature and support efforts to address climate change.

2.6 Further links to health and wellbeing can be found throughout the framework including in sections on housing, transport, design, and the natural environment.

National Planning Practice Guidance (NPPG), November 2019

2.7 The NPPF is supported by additional guidance set out in NPPG specifically in the 'Healthy and Safe Communities' category. This acknowledges that the design and use of built and natural environments are major determinants of health and wellbeing. It states that planning and health need to be considered together in terms of creating environments that support and encourage healthy lifestyles.

2.8 Paragraph 3 describes a healthy place as one which:

- Supports and promotes healthy behaviours and environments and a reduction in health inequalities for people of all ages.
- Provides opportunities to improve physical and mental health and supports engagement and wellbeing.
- Is inclusive and promotes social interaction.
- Meets the needs of children and young people to grow and develop as well as being adaptable to the needs of an increasingly elderly population and those with sensory or mobility impairments.

2.9 Paragraph 5 states that it is helpful to consult Public Health on planning applications that are likely to have a significant impact on the health and wellbeing of the local population or particular groups, this would allow partnership working on any necessary mitigation measures. It also mentions that a health impacts assessment is a useful tool to use where there are expected to be significant impacts.

2.10 County Policy Context:

- Healthy lives, healthy people: East Sussex Health and Wellbeing Board Strategy | East Sussex County Council
- Annual Report of Director of Public Health 'Health and Housing', 2019/20
- East Sussex Whole-System Healthy Weight Plan 2021-2026
- Sussex Integrated Care Strategy

- East Sussex Environment Strategy 2020
- East Sussex Joint Strategic Needs Assessment (JSNA)
- ESCC Local Plans
- ESCC Local Transport Plan

2.11 Local Policy Context:

- Eastbourne Corporate Plan 2022-2026
- Eastbourne Borough Council Biodiversity Strategy, 2021
- A Whole Systems Approach to Creating Health Equity, and Prosperity in Hastings
- Healthy Hastings and Rother – Working Together to Reduce Health Inequalities, Summer 2019
- Lewes District Council Corporate Plan, 2020-2024
- Lewes District Council Biodiversity Strategy, 2021
- Rother's Corporate Plan, 2020-2027
- People and Nature Network: Green Infrastructure in the South Downs and wider South East
- South Downs National Park, Partnership Management Plan, Outcome Health and Wellbeing
- South Downs National Park Authority Health and Wellbeing Strategy
- Wealden Health and Wellbeing Strategy

3 Conclusion and reasons for recommendations

3.1 The development of an East Sussex Public Health and Planning Memorandum of Understanding (MOU) in conjunction with the Borough and District Councils has the potential to improve outcomes for the population of East Sussex and can be referenced across to support the development of wider policies and programmes of work that support the delivery of the affiliated priorities and policies.

3.2 The Health and Wellbeing Board is recommended to note the Memorandum of Understanding between the County Council and the District and Borough Councils in respect of planning from a Public Health perspective.

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Director of Public Health

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BACKGROUND DOCUMENTS

- Health in all policies- a manual for local government (2016)
- Health Impact Assessment in spatial planning: A guide for local authority public health and planning teams (PHE 2020)
- Our Planet, Our Health (House of Commons Environmental Audit Committee 2019)

- Healthy Placemaking: The evidence on the positive impact of healthy placemaking on people is clear – so how can we create places that deliver healthier lives and help prevent avoidable disease? (Social Change UK 2018)
- National Planning Policy Framework (2021)
- www.tcpa.org.uk/healthyplanning
- Building for Life: The sign of a good place to live (January 2015)
- Healthy Placemaking (TCPA)
- Spatial Planning for Health: An evidence resource for planning and designing healthier places (PHE 2017)
- Health and Wellbeing in Homes (UK Green Building Council 2016)
- PHE and partners: Healthy weight environments: using the planning system (2020)
- Building the Foundations: Tackling Obesity through Planning and Development TCPA & LGA (2016)
- Rising to the Climate Crisis: A Guide for Local Authorities on Planning for Climate Change
- Town and Country Planning Association's report on 'Securing constructive collaboration and consensus for planning healthy development (2018)
- Health in Environmental Impact Assessment. A briefing for public health teams in England by PHE
- Spatial Planning and Health Getting Research into Practice (GRIP): study report (PHE 2019)

Appendix 1 – East Sussex Planning and Public Health Memo of Understanding

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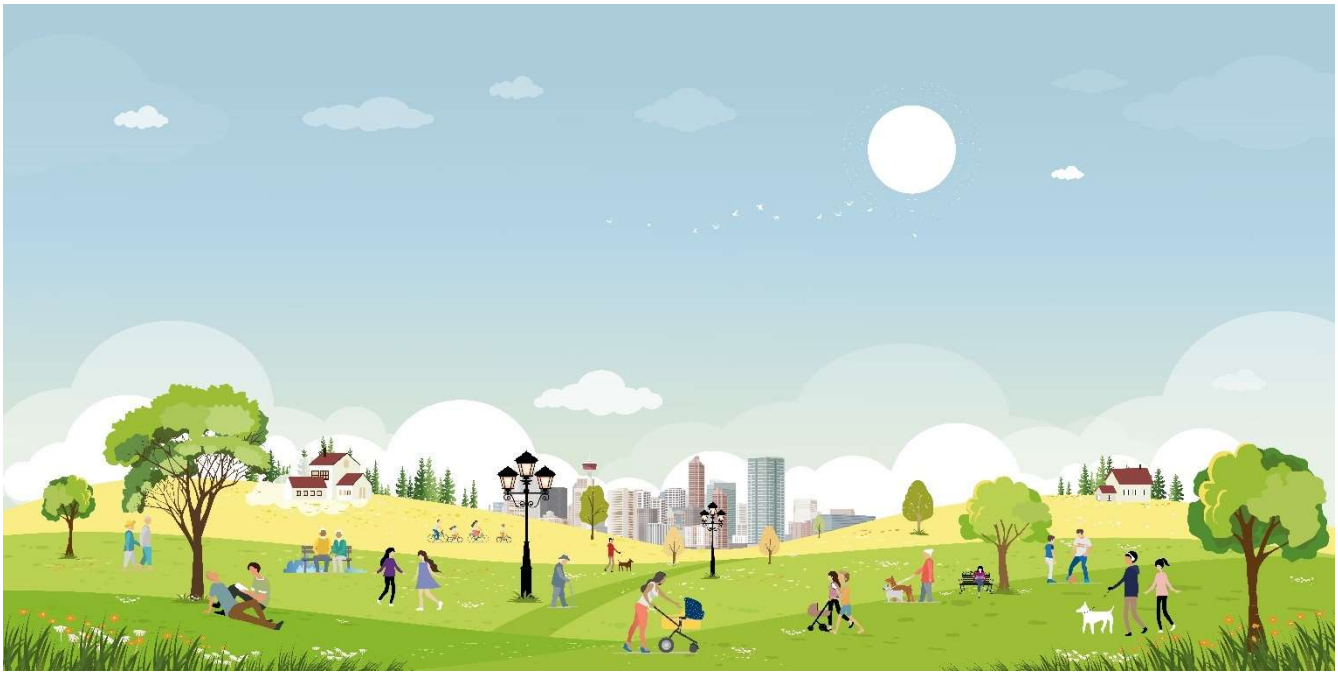
East Sussex Public Health and Planning Memorandum of Understanding

August 2022



Contents

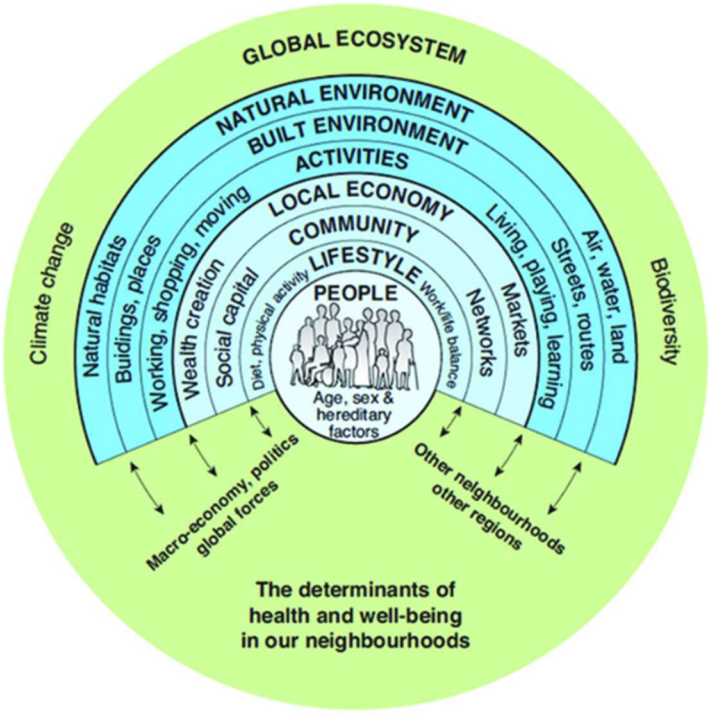
1. Purpose

1.1 This Memorandum of Understanding (MOU) sets out how the Public Health Team within East Sussex County Council (ESCC) and Local Planning Authorities (LPAs) will work together to deliver the County Council's statutory public health responsibilities and LPAs duties to deliver relevant elements of the National Planning Policy Framework through the planning system. This MOU includes all LPAs within East Sussex which are Eastbourne Borough Council, East Sussex County Council, Hastings Borough Council, Lewes District Council, Rother District Council, South Downs National Park Authority and Wealden District Council.

1.2 This MOU provides the policy context and links between planning and health. It provides an overarching agreement and intention to work together countywide to improve the health and wellbeing of our residents. It sets out the high-level actions that parties will take, including working together to agree specific actions around processes, engagement, and parameters to establish robust working outcomes and objectives. These will be developed into detailed agreements between Public Health and individual LPAs.

2. Background

2.1 Population health and wellbeing is impacted not only by individual behaviour, but by the wider determinants such as those within the built and natural environment as depicted below:



The Health Map (Barton and Grant 2006)

2.2 Some of the most pressing health challenges: such as obesity, mental health issues, physical inactivity, and the needs of an ageing population, can all be influenced by the quality of our built and natural environment. These wider determinants of health are influenced by the planning system and therefore improving both physical and mental health and wellbeing is integral to land use planning. This is through areas such as place-making, design, regeneration, sustainable development, green infrastructure, active and sustainable travel, and development management. The links between health and planning are recognised in the National Planning Policy Framework 2021 (NPPF) and its accompanying Practice Guidance (NPPG).

2.3 It is acknowledged that whilst most of the public health agenda is nothing new for land use planning there is growing policy, guidance, and evidence of the specific links between the two areas and therefore there is now a real opportunity to strengthen how health and wellbeing is addressed within the planning system. This will add value not only to existing work which already considers health impacts and inequalities but will also support work addressing shared objectives with health on tackling the climate change emergency and delivering an economic recovery post Covid 19.

2.4 It is also acknowledged that other health teams and organisations input into the planning system to improve health and wellbeing such as environmental health teams, health and wellbeing teams in district authorities and the National Health Service (NHS). This MOU will support and link in with the work being done by these other partners.

2.5 This MOU has been developed between public health and planning officers to build consensus and mutual understanding. It will build consistency across the county in the approach to creating healthy and sustainable places, strengthening compliance to the Duty to Cooperate. It will also be a mechanism which will help to deliver against the East Sussex Health and Wellbeing Strategy, the Creating Healthy and Sustainable Places – A Framework for East Sussex, and Local Plan policy objectives concerning health, wellbeing, and sustainability.

3. National Policy Context

Health and Social Care Act

3.1 In April 2013 the Health and Social Care Act (2012) gave upper tier and unitary authorities a new duty to improve the health of people in their area including encouraging healthier lifestyles and addressing health inequalities. The transfer of responsibilities from the NHS to local government was intended to shift the emphasis from treatment towards a more preventative agenda which tackles the wider social determinants of health such as the environment, housing, education, and employment.

3.2 As part of the Health and Social Care Act local areas had to establish multi-agency Health and Wellbeing Boards. The Boards are charged with producing the Joint Strategic Needs Assessment and a Joint Health and Wellbeing Strategy for their local areas.

Integrated Care Systems (ICSs)

3.3 Constraints on NHS funding over the past seven years, combined with rising demand from a growing ageing population, have put the NHS under enormous pressure. It has been clear for some time that simply working our current hospital-based model of care harder to meet rising demand is not the answer. Rather, the NHS needs to work differently by providing more care in people's homes and the community and breaking down barriers between services.

3.4 The NHS also needs to give greater priority to the prevention of ill health by working with local authorities and other agencies to tackle the wider determinants of health and wellbeing. This means tackling risk factors such as obesity and redoubling efforts to reduce health inequalities. And it means fully engaging the public in changing lifestyles and behaviours that contribute to ill health and acting on the recommendations of the Marmot Review Report 'Fair Society, Healthy Lives'(2010) and other reviews to improve population health.

3.5 ICSs are geographically based partnerships that bring together providers and commissioners of NHS services with local authorities and other local partners to plan, co-ordinate and commission health and care services. They are part of a fundamental shift in the way the health and care system is organised – away from competition and organisational autonomy and towards collaboration, with health and care organisations working together to integrate services and improve population health. Integrated care partnerships (ICPs) will operate as a statutory committee, bringing together the NHS and local authorities as equal partners to focus more widely on health, public health, and social care. ICPs will include representatives from the Integrated Care Boards (ICB), the local authorities within their area and other partners such as NHS providers, public health, social care, housing services, and voluntary, community and social enterprise (VCSE) organisations. They will be responsible for developing an integrated care strategy, which sets out how the wider health needs of the local population will be met.

National Planning Policy Framework, 2021 (NPPF)

3.6 The NPPF requires public health to be considered in both plan-making and decision-taking and states the purpose of planning is to contribute to the achievement of sustainable development, with delivery of the social objective of sustainable development being paramount to supporting health.

3.7 The social objective in paragraph 8b supports strong, vibrant, and healthy communities, by ensuring that a sufficient number and range of homes can be

provided to meet the needs of present and future generations; and by fostering well-designed, beautiful, and safe places, with accessible services and open spaces that reflect current and future needs and support communities' health, social and cultural wellbeing.

3.8 Section 8 'Promoting healthy and Safe Communities' paragraph 92, requires planning policies and decisions to aim to achieve healthy, inclusive, and safe places which promote social interaction, that are safe and accessible, and enable and support healthy lifestyles, especially where this would address identified local health and wellbeing needs.

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3.10 Paragraph 98 recognises the importance of access to a network of high-quality open spaces and opportunities for sport and physical activity for health and wellbeing of communities which can also deliver wider benefits for nature and support efforts to address climate change.

3.11 Further links to health and wellbeing can be found throughout the framework including in sections on housing, transport, design, and the natural environment.

National Planning Practice Guidance (NPPG), November 2019

3.12 The NPPF is supported by additional guidance set out in NPPG specifically in the 'Healthy and Safe Communities' category. This acknowledges that the design and use of built and natural environments are major determinants of health and wellbeing. It states that planning and health need to be considered together in terms of creating environments that support and encourage healthy lifestyles.

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- Supports and promotes healthy behaviours and environments and a reduction in health inequalities for people of all ages.
- Provides opportunities to improve physical and mental health and supports engagement and wellbeing.
- Is inclusive and promotes social interaction.
- Meets the needs of children and young people to grow and develop as well as being adaptable to the needs of an increasingly elderly population and those with sensory or mobility impairments.

3.14 Paragraph 5 states that it is helpful to consult Public Health on planning applications that are likely to have a significant impact on the health and wellbeing of the local population or particular groups, this would allow partnership working on any

necessary mitigation measures. It also mentions that a health impacts assessment is a useful tool to use where there are expected to be significant impacts.

4. County Policy Context

East Sussex Health and Wellbeing Board Strategy 'Healthy Lives, Healthy People', 2022-2027

4.1 The Strategy's vision is to protect and improve health and wellbeing and reduce health inequalities in East Sussex, so that everyone has the opportunity to have a life that is as safe, healthy, happy and fulfilling as possible.

4.2 The Strategy recognises that health and wellbeing is not just about services, it is improved by access to good jobs, transport, housing and green space as well as opportunities for learning, exercise, good nutrition and supportive networks and relationships within communities. The priorities include promoting strong awareness of the impact of these wider determinants and seeking to engage everyone to play their part to ensure those determinants are as positive as possible in the county.

4.3 It recognises the partnership work being undertaken to develop shared plans in other areas that influence the health of the local population. It stresses the importance of making sure that all organisations can play an effective part in delivering these strategies and plans. This includes local planning authorities bringing together plans aimed at creating healthy and sustainable places across the built and natural environment and other factors that affect health and wellbeing locally.

Annual Report of Director of Public Health 'Health and Housing', 2019/20

4.4 The report illustrates the very strong link between our physical, emotional, and mental wellbeing and our living environment. It states that people living in areas of deprivation and those who are already vulnerable suffer the most harm in relation to physical health and emotional and mental wellbeing and for children, future life chances.

4.5 The report shows that housing related harm is largely hidden, including the impact of living in insecure accommodation or poor-quality housing. It indicates by taking a whole systems approach in-roads can be made to improve the availability of affordable, decent housing; reduce inequalities; and improve health and wellbeing.

4.6 The report makes strategic recommendations to build on the existing work and strengthen the ability of housing in East Sussex to secure good health for all, these include:

- **To make all housing and neighbourhoods healthy:** ESCC and the District and Borough Councils will work more collaboratively on Local Plans, sharing data

and intelligence to fully understand housing needs and hardwiring the principles of 'Putting health into place' to ensure health is central to place making, and the design and delivery of homes and neighbourhoods.

- **To make all homes healthy:** ESCC, the District and Borough Councils and the NHS will support and promote initiatives that improve the health and safety of homes, including adaptations that improve environmental sustainability, and promote independent living.

East Sussex Whole-System Healthy Weight Plan 2021-2026

4.7 The Plan highlights that living with excess weight is a well-established risk factor for a range of chronic diseases, including type 2 diabetes, cardiovascular disease, many cancers, liver, and respiratory disease.

4.8 Partners across the whole system need to work together to address all the causal factors which lead to an unhealthy weight and physical inactivity. This includes improving access to and safety of cycle lanes, ensuring planning and development prioritises physical activity and making our outdoor spaces safe and accessible for all.

4.9 Three priority action areas were chosen: environment, physical activity, and food. Specific actions under these include:

- **Physical activity:** Make walking and cycling the easier choice for short journeys or part of longer journeys wherever possible.
- **Food:** Create an environment where healthy food is the preferred choice, whether eating in or out of the home.
- **Environment:** Ensure that healthy weight and physical activity is prioritised within local planning and development processes; and improve access, promotion, and safety of public outdoor spaces, and encourage a sense of shared ownership by those who use them.

4.10 The Action Plan includes the area: Creating a healthier weight environment. This includes the structures level action:

> 'Work with the local planning authorities to embed a 'health in all policies' approach to their planning processes e.g. health impact assessments, design guides, supplementary planning documents, etc. which support a 'healthier weight' environment.'

And the belief action:

> 'All organisations with responsibility for planning in East Sussex recognise and prioritise getting 'health into place' in their local areas.

East Sussex Environment Strategy 2020

4.11 The strategy sets out the key challenges and opportunities within five priority environmental themes: climate change, natural capital, air quality, water, and resource efficiency. The environmental challenges make it clear that urgent action

is needed, however these also provide opportunities. It stresses that investing in a healthier and more productive environment will deliver economic and social benefits and is essential for sustainable social and economic prosperity. The benefits include improved health outcomes and reduced health costs.

4.12 Reducing the impact of environmental pollution on health, notably air pollution will reduce mortality and morbidity rates. The strategy's long-term aim is for all of East Sussex to meet the air quality standards recommended by the World Health Organisation. Spending time in the natural environment improves mental health and wellbeing, by reducing stress, anxiety, and depression, whilst physical activity measurably reduces the risk of type 2 diabetes, heart disease and hip fractures. The strategy's long-term aim is to achieve a growing and resilient stock of natural capital.

East Sussex Joint Strategic Needs Assessment (JSNA)

4.13 The JSNA provides a detailed information base on the health of the local population in areas relevant to planning. Local Health Profiles identify local public health inequalities and priorities which require improvements to overall health and wellbeing.

ESCC Local Plans

4.14 The County Council is the local planning authority for its own development (for example libraries and roads) and determines planning applications for such proposals. The County Council is also the waste and minerals planning authority for East Sussex. As such it determines planning applications for waste management and minerals development, and also is required to prepare waste and minerals planning policies for the area. The adopted Waste and Minerals Local Plan, prepared jointly with Brighton & Hove City Council and the South Downs National Park Authority (SDNPA) is currently being reviewed with Examination expected later in 2022.

ESCC Local Transport Plan

4.15 As Highway Authority the County Council is responsible for producing the Local Transport Plan. Work is currently being undertaken on Local Transport Plan 4 (LTP4). This provides an opportunity for Public Health to work with transport planners and with local planning authorities to ensure health and wellbeing issues related to travel are consistently addressed and opportunities for benefits are maximised.

4.16 The Local Transport Plan is supported by other key documents such as the ESCC Local Cycling and Walking Infrastructure Plan and the ESCC Bus Service Improvement Plan and forthcoming thematic plans which will be developed as part of LTP4 in relation to Strategic Road & Rail, Freight and Smart Mobility.

5. Local Policy Context

Local Plans

5.1 Local Plans, which set the levels and location of future development, are produced in East Sussex by districts, boroughs, and the SDNPA. All LPAs are currently reviewing their Local Plans and are at a relatively early stage in their development, this provides a key opportunity for health and wellbeing to be strengthen within these emerging plans.

Eastbourne Corporate Plan 2022-2026

5.2 The Eastbourne Corporate Plan identifies a vision for strong communities where individual residents and their different organisations and support networks have the resources they need to be healthy, feel safe and thrive.

5.3 As part of the priority for Thriving Communities, Eastbourne will promote physical health and mental well-being through working with Wave Leisure, other activity providers and the East Sussex Public Health team to promote physical activity; improving the facilities provided at the Sovereign Leisure Centre; and promoting walking and cycling as both leisure and commuting opportunities.

5.4 In addition, the Corporate Plan aims to promote homes that sustain health and well-being through measures such as developing integrated health, housing and care strategies, and improving infrastructure through new integrated cycling and walking routes.

Eastbourne Borough Council Biodiversity Strategy, 2021

5.5 Eastbourne Borough Council is committed to supporting measures to help arrest biodiversity losses, restore habitats and species and work for climate resilience to promote healthy and thriving communities. This is recognised through the biodiversity strategy, with the need to protect and maintain as well as enhance and increase biodiversity and nature across Eastbourne.

A Whole Systems Approach to Creating Health Equity, and Prosperity in Hastings

5.6 In June 2021 the Hastings Local Strategic Partnership (LSP) Board agreed to establish a health inequalities task and finish working group. This was in part in response to the motion to Hastings Council in February 2021 regarding health inequalities, in recognition that across Hastings 74% of the population is living in the worst 20% deprived communities in England.

5.7 The discussion paper ‘Creating Health Equity and Prosperity in Hastings a Whole Systems Approach’ was endorsed by the LSP in June 2022. The paper provides

recommendations to capture, identify and deliver key actions across services and organisations in which to tackle the wider determinants of health, create health equity and prosperity in Hastings across the 'whole system'. A whole system approach is a long-term endeavour and seeks to work with communities and stakeholders to both understand the problem and to support identification and testing of solutions.

Healthy Hastings and Rother – Working Together to Reduce Health Inequalities, Summer 2019

5.8 The Healthy Hastings and Rother programme was set up in 2014 by the NHS East Sussex CCG (now known collectively as the Integrated Care Board, NHS Sussex) to tackle long-standing problems of relative poor health in Hastings and Rother, aimed at reducing health inequalities by improving local services and supporting people to live healthy and happy lives.

5.9 Hastings and Rother contain the eight most deprived council wards in East Sussex. These experiences of deprivation contribute to higher rates of long-term illness, disabilities, cancer, lung disease and heart problems as compared with the rest of England. The programme aims to reduce health inequalities by improving the health and wellbeing of people in Hastings and Rother's most disadvantaged communities.

Lewes District Council Corporate Plan, 2020-2024

5.10 The Corporate Plan sets out the goals and ambitions for the 4-year period. One area of focus under Sustainability and Climate Change is to improve air quality through the development of a district Air Quality Action Plan. This will combine and update the two current Action Plans which focused on the two Air Quality Management Areas (Lewes Town centre and Newhaven). Another area of focus under this theme seeks to improve the energy efficiency of homes including supporting low-carbon heating technologies in our council houses.

Lewes District Council Biodiversity Strategy, 2021

5.11 Lewes District Council's broad key aims within the strategy can be summarised as follows:

- To seek nature-based solutions, ecosystem services and re-naturing or rewilding opportunities as guiding principles in all council and partnership endeavours.
- To maintain and increase biodiversity on council-owned and managed land.
- To engage and enable community-led nature-based projects and to be involved in partnerships that promote natural capital and biodiversity across the district.
- To ensure that all developments maximise the opportunities for well-considered gains in biodiversity.

5.12 The council is committed to supporting measures to help arrest biodiversity losses, restore habitats and species and work for climate resilience to promote healthy and thriving communities. This is recognised through this strategy, with the need to protect and maintain as well as enhance and increase biodiversity and nature across Lewes District.

Rother's Corporate Plan, 2020-2027

5.13 A priority objective of the Corporate Plan is to build a fairer society. A series of aims have been set to achieve this including, amongst other things, developing an Anti-Poverty Strategy (published in draft in April 2022). This identifies significantly higher levels of people with long term health problems in Rother compared to the south-east region and to England and Wales. An additional Corporate Plan aim is to improve levels of physical activity amongst residents experiencing socio-economic deprivation and poor health outcomes.

People and Nature Network: Green Infrastructure in the South Downs and wider South East

5.14 The South Downs People and Nature Network (PANN) was published in 2020. The PANN aims to protect, enhance and create a network of green and blue spaces which sustainably meet the needs of local communities, support natural ecosystem services and respects the special qualities of protected landscapes by proposing the strategic principles for planning, delivery and management of natural capital assets in the area. It recognises the importance of nature for health and wellbeing. Objectives include using natural assets to support health and wellbeing and improving access opportunities to greenspaces. The PANN area shows information beyond the SDNP, showing important relationships between, and opportunities for, people and nature across a wider area. A full evidence report accompanies the PANN which includes data related to health and wellbeing. A series of Natural Capital Investment Areas are identified, accompanied by an analysis of the strengths, weaknesses, opportunities, and threats particular to that area.

South Downs National Park, Partnership Management Plan, Outcome Health and Wellbeing

5.15 The South Downs National Park is a well-used and recognised asset for sustaining mental and physical health and wellbeing. The South Downs Partnership Management Plan 2020-2025 includes outcome 7 on health and wellbeing. For this outcome the priorities for the next five years are to develop initiatives which enable local communities and individuals to improve health and wellbeing. The Authority is building a partnership with health bodies and local networks of providers and commissioners, both in and around the National Park, to encourage a better appreciation of the potential of the South Downs as a place for healthy outdoor

activity and relaxation, and as a place where mental health and emotional wellbeing can be nurtured and supported.

South Downs National Park Authority Health and Wellbeing Strategy

5.16 The South Downs Health and Wellbeing Strategy 2020-2025 sets out the ambition for Health and Wellbeing is that the South Downs National Park is a well-used and recognised asset for sustaining mental and physical health and wellbeing across all sectors of the community. The strategy sets objectives and a delivery action plan under three themes: (1) realising wellbeing benefits for communities, (2) realising wellbeing benefits for individuals and (3) Promoting the South Downs National Park as a place for health and wellbeing. Several spatial health and wellbeing priority areas are also identified.

Wealden Health and Wellbeing Strategy

5.17 The Strategy sets out Wealden District Council's health and wellbeing priorities to improve and protect the health and wellbeing of all those who live and work in the district as well as maintain Wealden as a healthy place to live, work or visit. The Strategy provides details on how the Council intend to deliver its health and wellbeing agenda over the next three years. The priorities include: Mental health and resilience: Loneliness, social isolation and connected communities; Positive health choices; and Active communities, environment, and facilities.

6. Links between Planning and Health

6.1 The following section outlines the potential links between planning principles and measures and health and wellbeing impacts and outcomes. The information has been adapted from 'Public Health England's Spatial Planning for Health'[1] and 'Strengthening the links between planning and health in England'[2].The section is grouped under the 5 aspects of the built and natural environment that have been identified as the main characteristics that can be influenced by local planning policy:

- Neighbourhood design
- Housing
- Healthier food
- Natural and sustainable environment
- Transport

6.2 These aspects of the lived environment can be designed and shaped, by planners, to promote certain health outcomes. Changes to the design of the environment can support improvements in health and reduce the risk of developing certain diseases,

[1] Public Health England. Spatial planning for health: evidence review. PHE publications, 2017.
[2] Strengthening the links between planning and health in England, 2020, Gemma McKinnon, Helen Pineo, Michael Chang, Laura Taylor-Green, Annalise Johns and Rachel Toms

and also help to improve people's physical and mental wellbeing. Many of planning principles will already be being considered but a greater understanding of the potential health and wellbeing impacts and/or benefits can support and further justify the inclusion and implementation of policies and measures to address them.

6.3 Various organisations influence the planning system and help to deliver and address these planning principles and measures. Environmental Health Teams, that sit within district and borough councils and the SDNPA, monitor and control environmental pollution to reduce chemical and other environmental exposures in air, water, soil, and food to protect people and provide communities with healthier environments. The NHS through Sussex NHS Commissioners is responsible for providing additional healthcare facilities to meet increased population growth. Wealden District Council has a Health and Wellbeing Team who work with a variety of partners to delivery health activities, interventions, and programmes within the district.

6.4 Neighbourhood Design

Planning principles and measures ➔	Impact on health and wellbeing ➔	Health and wellbeing outcomes
Improved connectivity and walkability. Mix of land uses with provision of services: health, education, retail, community, cultural and recreational. Local employment, workspaces, and training opportunities. Inclusive and accessible places and buildings for all ages and abilities. Well-designed attractive, safe public realm where people can meet.	Social engagement, interaction, and cohesion Increased physical activity opportunities for all. Improved access to health and social facilities, services, and employment. Reduction in harmful pollutants due to reduced reliance on cars.	Improved mental wellbeing. Reduced risk of cardiovascular disease. Reduced risk of type 2 diabetes. Keeping musculoskeletal system healthy. Reduced obesity and overweight levels and associated conditions. Improved mobility among older adults.

6.5 Housing

Planning principles and measures ➔	Impact on health and wellbeing ➔	Health and wellbeing outcomes
Improved quality of housing. Good design including orientation, ventilation, and energy efficiency. Increased provision of affordable and diverse housing for all, including groups with specific needs for example elderly and disabled.	Warmth and energy efficiency. Improved indoor air quality and light exposure. Improved engagement with healthcare services.	General health improvements. Asthma outcomes improved. Reduction in excess winter deaths. Reduced risk of cardiovascular disease, type 2 diabetes, some cancers. Improved quality of life and mental wellbeing.

6.6 Healthier Food

Planning principles and measures ➔	Impact on health and wellbeing ➔	Health and wellbeing outcomes
Community food growing infrastructure including allotments and gardens. Access to healthier, affordable food for all. Healthy highstreets with a diversity of shops and retail outlets selling healthier food.	Healthier eating and change in dietary behaviours. Change in attitudes towards healthy eating. Increased access to healthier food. Opportunities for physical activity and social connectivity.	Reduction in obesity and associated conditions. Improved mental health and wellbeing. Reduced risk of cardiovascular disease type 2 diabetes, stroke, some cancers and musculoskeletal conditions.

6.7 Natural and sustainable environment

Planning principles and measures ➔	Impact on health and wellbeing ➔	Health and wellbeing outcomes
Reduced exposure to environmental hazards (air and noise pollution, light and odour). Access to and engagement with nature. Safe, improved existing and new open green and blue natural spaces. Integrated play and recreation opportunities for all. Adaption to climate change: flood risk and temperature changes. Urban greening: street trees, green roofs, and walls.	Reduced exposure to particulate matter and excessive noise. Increased physical activity opportunities for all. Reduced impact from weather extremes (hot and cold). Social participation and cohesion.	Reduced risk of chronic obstructive pulmonary disease, reduction in infant mortality and improved respiratory function among children. Reduced risk of developing lung cancer. Reduction in obesity and associated conditions. Reduced risk of cardiovascular disease, type 2 Diabetes, stroke, mental health problems, musculoskeletal conditions, and some cancer. Improved mental wellbeing.

6.8 Transport

Planning principles and measures ➔	Impact on health and wellbeing ➔	Health and wellbeing outcomes
Safe, attractive active travel infrastructure for all which links to key destinations. Public transport opportunities. Prioritise active travel and road safety. Enable mobility for all ages and activities.	Increased mobility. Increased physical activity opportunities for all. Social participation and cohesion.	Reduction in obesity and associated conditions. Reduction in road traffic accident injuries. Reduced risk of cardiovascular disease and type 2 diabetes. Keeping musculoskeletal system healthy. Improved mental wellbeing.

7. Actions

7.1 The actions below are high-level countywide actions. Detailed actions and agreements on specific parameters, engagement, and processes, particularly around Health Impact Assessments (HIA) and planning application consultations, will be further discussed and agreed between Public Health and individual LPAs. These will be set out in further detailed agreements between Public Health and individual LPAs. This is in recognition of the further liaison required and that the needs of each LPA will vary.

7.2 Actions have been numbered for ease of reference only, there is no priority in the numbering.

Public Health will:

1. Work proactively with local planning authorities to develop programmes and policies which address public health objectives through the land use planning process.

2. Make the JSNA evidence base relevant and available to local planning authorities and provide advice and support in interpreting it and applying it to local circumstances. Where required submit further evidence on national and local policies and health needs. Where necessary this could include joint commissions to obtain evidence to support policies and actions which address specific local issues related to health inequalities.

3. Support LPAs when progressing policies to help ensure that policies address the issues and are customised to local circumstances as appropriate. This will include an early review of policies ahead of any formal consultation to assist LPAs in getting policies right ahead of consultation. Support LPAs should any health and wellbeing policy or initiative be challenged through the local plan preparation or planning application process.

4. Use the Healthy Places Team as a first point of contact for Public Health's input into the planning system on health and wellbeing issues. The Healthy Places Team will liaise with other teams and organisations to ensure links are made, and will provide formal comments to Local Plan and Neighbourhood Plan consultations through the existing coordinated County Council response provided by officers in the Communities, Economy and Transport Department.

5. Encourage and support NHS Estates and NHS health service commissioners, who are responsible for identifying and delivering healthcare facilities, in responding to consultations on local plans, including infrastructure delivery plans and major planning applications. This should help to ensure the requirement for healthcare facilities and public health population needs are given full consideration in both local plans and planning decisions.

6. Provide support to planning authorities to help identify appropriate trigger points for HIA within local areas, as appropriate.

7. Support planning authorities to develop and implement HIA including providing training as necessary and consider developing any necessary specific countywide tools and guidance. Work with LPAs to develop an appropriate approach and process on implementing HIA including Quality Assurance. Specific working arrangements will be agreed and set out within detailed agreements with individual authorities.

8. Work with LPAs to establish a process for consulting Public Health on applications both at pre application and submission stages. Parameters and processes will be within existing processes, resources, and capacities wherever possible. Specific working arrangements will be agreed and set out within detailed agreements with individual authorities.

Local Planning Authorities will:

1. Endeavor to include an overarching strategic policy in Local Plans on health and wellbeing that sets out the overall principles of planning for health and wellbeing and how the plan will meet NPPF requirements to achieve healthy, inclusive, and safe places which will reduce health inequalities and promote healthier lifestyles.

2. Ensure all policies reflect planning for health and wellbeing priorities and principles (Health and Environment in All Policies) either on their own or in combination with the overarching health and wellbeing strategic policy.

3. Use the JSNA, academic evidence and other sources of intelligence as the evidence base for policy making and decision making and ensure local plans and decisions reflect the issues set out.

4. Consult Public Health on early Local Plan policy development and consider incorporating comments ahead of formal consultations. Work in partnership with Public Health on the development of policy documents such as Supplementary Planning Documents, Technical Advice Notes that relate to health and wellbeing including design guides and codes and Green and Blue Infrastructure Strategies.

5. Include health and wellbeing related infrastructure within Infrastructure Delivery Plans and as appropriate in other strategies and plans such as Green and Blue Infrastructure Strategies. Involve PH in securing and allocating development contributions as appropriate.

6. Ensure health and wellbeing is adequately incorporated into assessments of Local Plans for example a Sustainability Appraisal and/or undertake a separate HIA.

7. Work towards requirement for a HIA for appropriate development in Local Plans and Local Validation Lists. Liaising with Public Health to assist in identifying appropriate triggers points for undertaking an assessment. Work with Public Health to develop an appropriate approach and process on implementing HIA including Quality Assurance. Specific working arrangements will be agreed and set out within detailed agreements between individual authorities and Public Health.

8. Work with Public Health to establish a process for involving them in pre-application discussions for major developments above an agreed size threshold and/or agreed areas of deprivation. Specific working arrangements will be agreed and set out within detailed agreements between Public Health and individual authorities.

9. Work with Public Health to establish a process for consulting them on planning applications for development and change of use or prior approval notification of developments where a potential public health impact is expected, or developments are above an agreed size threshold. Parameters and processes will be within existing processes, resources, and capacities wherever possible. Specific working arrangements will be agreed and set out within detailed agreements between Public Health and individual authorities.

Signed on behalf of Public Health, East Sussex County Council

Print Name: Darrell Gale

Date: 22.09.22

Position: Director of Public Health

Signed On behalf of Eastbourne Borough Council

Print Name: Leigh Palmer

Date: 12/08/22

Position: Head of Planning

Signed on behalf of Hastings Borough Council

Print Name: Jane Hartnell

Date: 26/09/22

Position: Managing Director

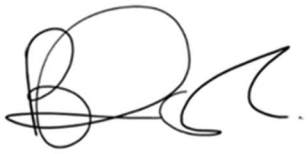
Signed on behalf of Lewes District Council

Print Name: Leigh Palmer

Date: 12/08/22

Position: Head of Planning

Signed on behalf of Rother District Council



Print Name: Ben Hook

Date: 16 August 2022

Position: Director of Place and Climate Change

Signed on behalf of South Downs National Park Authority

Print Name: Lucy Howard

Date: 01-09-22

Position: Planning Policy Manager

Signed on behalf of Wealden District Council

Print Name: Nichola Watters

Date: 30.09.22

Position: Head of Planning Policy, Economy, and Climate Change

Signed on behalf of East Sussex County Council as County Planning Authority

Print Name: Edward Sheath

Date: 5 October 2022

Position: Head of Planning & Environment

Report to:	**Health and Wellbeing Board**
Date of meeting:	**27 June 2023**
By:	**Director of Public Health**
Title:	**Pharmacy closures in East Sussex-update for the Board**
Purpose:	**To receive updates on recent changes in pharmacy provision in East Sussex and approve recommendations of the Pharmaceutical Needs Assessment Steering Group regarding supplementary statements.**

***RECOMMENDATIONS*: The Health and Wellbeing Board is recommended to:**

1) **Approve the removal of the Supplementary Statement posted regarding Lloyds Pharmacy (in Sainsburys) St Leonards;**
2) **Agree that no supplementary statement will be required regarding Lloyds Pharmacy (in Sainsburys) Hampden Park; and**
3) **Approve the issue of a Supplementary Statement for Lloyds Pharmacy in Sainsburys in Newhaven.**

1 Background

1.1 This update to the board is provided to:

- Clarify the current situation regarding changes to pharmacy provision for the Lloyds pharmacies in East Sussex and also any other relevant changes to contract and commissioning arrangements.
- Confirm the role of the Pharmaceutical Needs Assessment (PNA) when considering changes to pharmacy provision.
- Update the board on work that has been undertaken since the last Health and Wellbeing Board.
- Approve the recommendations from the PNA Steering Group regarding the issuing of Supplementary Statements.

2 Latest position

2.1 The Health and Wellbeing Board (HWB) have been notified of the following changes.

Pharmacy Name [Code]	**Location**	**Status As at 6/06/2023**	**Date of notification to HWB**	**Date of changes**
Lloyds Pharmacy in Sainsburys [FF388]	John Macadam Way, St Leonards, TN37 7SQ	Closed	6/2/2023	06/03/23
Lloyds Pharmacy in Sainsburys [FGW00]	The Drove, Newhaven, BN9 0AG	Closing	6/2/2023 9/5/2023	Original closure date: 23/07/23 Now closing: 13/06/23
Lloyds Pharmacy in Sainsburys [FVH64]	Broadwater Way, Hampden Park, Eastbourne, BN22 9PW	Closing	6/2/2023 9/5/2023	Original closure date: 23/07/23 Now closing: 13/06/23
Lloyds Pharmacy [FG055]	The Green, Newick, BN8 4LA	Transferred ownership to Waremoss*	19/04/23	19/04/23
Lloyds Pharmacy [FJQ76]	Turkey Road, Sidley, Bexhill-on-Sea, TN39 5HE	Transferred ownership to HealthyMed*	14/04/23	17/03/23

*The new owners have confirmed they will provide the same services as the previous owner.

2.2 The following Lloyds pharmacies in East Sussex remain open and we have received no notifications of changes as of 6th June 2023.

Pharmacy Name	Location
Lloyds Pharmacy [FAF25]	Anchor Fields, Ringmer, BN8 5QN
Lloyds Pharmacy [FE086]	The Square, Forest Row, RH18 5ES
Lloyds Pharmacy [FN068]	Battle Road, St Leonards, TN37 7AN

2.3 The issue regarding the palliative care medicines hub in Lloyds Pharmacy Newhaven, supporting the palliative care locally commissioned service, as raised at the March HWB meeting, has been resolved. Other nearby pharmacies [Boots in Newhaven and pharmacies in Seaford] have been contracted by the Integrated Care Board to provide this service.

2.4 Whilst contractors are required to give notice of closures, they are not required to give a reason. The contractor is required to give 3 months' notice to the relevant Integrated Care Board unless the pharmacy is a 100-hour pharmacy and in which case 6 months' notice is required.

2.5 At the previous Health and Wellbeing Board, concerns were raised about 100-hour contracts and potential changes to those contracts. The 100-hour contracts were issued under the former "exemption from control of entry test". This allowed them to open without the same level of entry requirements as other contractors. The 2013 Pharmacy Regulations (as amended) do not contain that exemption, therefore no further 100-hour contracts can be issued. However, there are pharmacies offering more than 40 core hours. These additional hours will be supplementary hours and agreed with NHS England.

2.6 NHS England and the Department of Health & Social Care have published the Community Pharmacy Contractual Framework 5-year deal: year 5 (2023 to 2024) update for contractors. This change will allow, if requested, current contractors of 100 hour pharmacies to reduce their hours to 72 per week, whilst maintaining agreed core hours.

2.7 On 9th May 2023, the Government announced a plan involving the introduction of pharmacy prescribing to improve patient access and alleviate pressure on general practices. What the Prime Minister's Primary Care Recovery Plan means for you - GOV.UK (www.gov.uk)

3 Role of PNA in considering changes in pharmacy provision

3.1 If a person (a pharmacy or a dispensing appliance contractor) wants to provide pharmaceutical services, they are required to apply to the relevant Integrated Care Board to be included in the pharmaceutical list for the Health & Wellbeing Board's area in which they wish to have premises. In general, their application must offer to meet a need that is set out in the Health and Wellbeing Board's PNA, or to secure improvements or better access similarly identified in the PNA.

3.2 However, there are some exceptions to this, such as applications offering benefits that were not foreseen when the PNA was published, known as 'unforeseen benefits applications'.

3.3 Every Health and Wellbeing Board (HWB) in England has a statutory responsibility to publish every three years, and keep up to date, a statement of the need for pharmaceutical services in its area, otherwise referred to as a Pharmaceutical Needs Assessment (PNA).

3.4 The NHS Sussex Integrated Care Board is responsible for managing the Community Pharmacy Contractual Framework and is expected to refer to the PNA when making decisions about Market Entry for new service providers, as well as in the commissioning of enhanced services from pharmacies. The required content for PNAs is set out in Schedule 1 to the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

3.5 If there is a change to the availability of pharmaceutical services, the Health and Wellbeing Board would need to consider whether the change is relevant to the granting of an application for inclusion in the pharmaceutical list. One way of doing that is to consider whether, when the Pharmaceutical Needs Assessment was written, if that pharmacy had not been there, would there have been a gap identified in the provision of pharmaceutical services.

3.6 When considering changes there are three options available.

- **Option 1** – No gap identified, ensure up-to-date map is available with PNA showing latest provision. No need to issue a Supplementary Statement.
- **Option 2** - Gap identified, PNA to be re-written and full consultation undertaken. In the meantime, issue a Supplementary Statement once the change has occurred. This is a statement of fact that provision has changed. Also ensure up-to-date map is available with PNA showing latest position.
  Option 3 - Gap identified but a re-write of the PNA seen as disproportionate. Issue a Supplementary Statement once the change has occurred. This is a statement of fact that provision has changed. Also ensure up-to-date map is available with PNA showing latest position.

3.7 Implications for each option

- **Option 1** – No implications on market entry.
- **Option 2** – May lead to applications to meet a current need that would be inferred by the publication of the Supplementary Statement. This gap would be clear in the publication of an updated PNA.
- **Option 3** – May lead to applications to meet a current need that would be inferred by the publication of the Supplementary Statement.

4 Work undertaken since last Health and Wellbeing Board

4.1 The PNA steering group met on 26th April 2023 to discuss the recent changes in pharmacy provision and consider the three options available for the Lloyds changes.

The steering group attendees included:

- **Chair** – Head of Public Health Intelligence, Public Health, ESCC
- Project Lead, Public Health Practitioner, Public Health, ESCC
- Consultation and Insight Officer, Adult Social Care, ESCC
- Admin Support Officer, Public Health, ESCC
- Senior Pharmacy & Commissioning Manager, Pharmacy & Optometry Team, NHSEI SE Region
- Chief Executive Officer, Community Pharmacy Surrey & Sussex, & East Sussex Local Pharmaceutical Committee (LPC)
- GP Interim Medical Director, Surrey & Sussex Local Medical Committee (LMC)
- Lay Member, Healthwatch, East Sussex

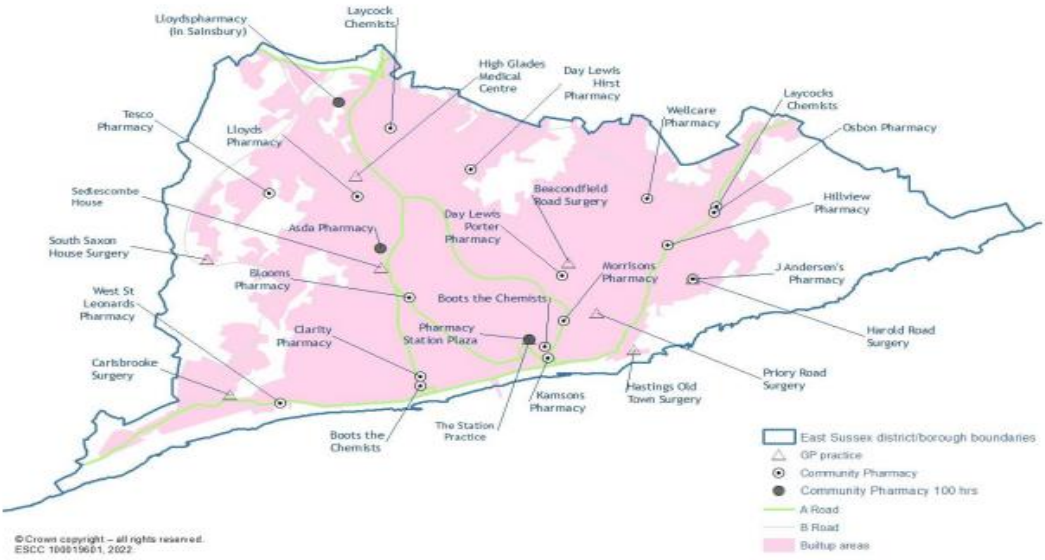
4.2 The steering group considered the following three changes.

Lloyds Pharmacy in Sainsburys [FF388], St Leonards, closed on 6th March 2023

4.3 There has been a loss of pharmacy services for some residents of Hastings and St. Leonards as a result of the closure. A national scheme, the Pharmacy Access Scheme, has been subsidising this pharmacy with the funding coming from the Community Pharmacy Contractual Framework. The scheme is designed to capture the pharmacies where patient and public access would be materially affected should they close.
https://www.gov.uk/government/publications/community-pharmacy-contractual-framework-2019-to-2024/2021-to-2022-pharmacy-access-scheme-guidance

4.4 Nonetheless, there is not sufficient loss of services to refer to this as a 'gap' in terms of NHS Market Entry rules. The group agreed that no gap would have been identified had it not been open at the time of the PNA. This is because there are four alternative pharmacies located nearby, in addition to a 100-hour pharmacy at Asda within reasonable travel time.

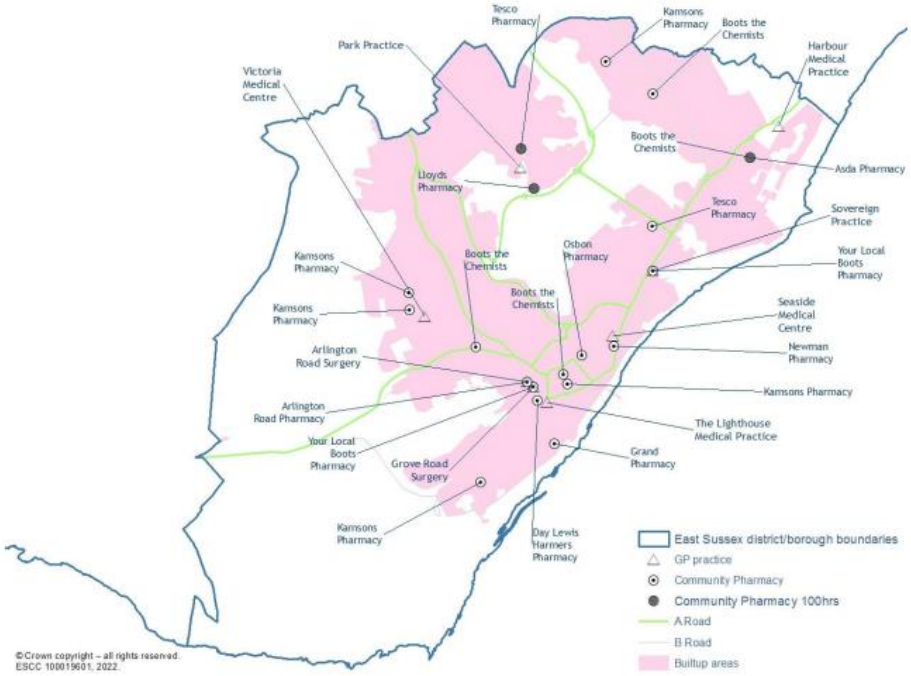
Map showing Lloyds pharmacy in the north of the Borough (figure 18 in PNA)



Lloyds Pharmacy in Sainsburys [FVH64], Hampden Park, closed on 13th June 2023

4.5 There has been a loss of pharmacy services for some residents of Eastbourne as a result of the closure. Nonetheless, there is not sufficient loss to refer to this as a 'gap' in terms of NHS Market Entry rules. The group agreed that no gap would have been identified had it not been open at the time of the PNA. This is because there is a 100-hour pharmacy open at Tesco very nearby.

Map from PNA showing Lloyds pharmacy in the central north of the Borough (Figure 17 in PNA)



Lloyds Pharmacy in Sainsburys [FGW00], Newhaven, closed on 13th June 2023

4.6 There has been a loss of pharmacy services for some residents in Lewes district as a result of the closure. There are two pharmacies open nearby whose opening hours between them include weekdays until 6:30, and all day on Saturday. However, neither are open on a Sunday. The nearest pharmacies open on a Sunday are located at Brighton Marina, Lewes town or Eastbourne. The steering group requested further information be gathered on public transport travel times to any pharmacy following the closure. There are no access problems for those who have access to a car.

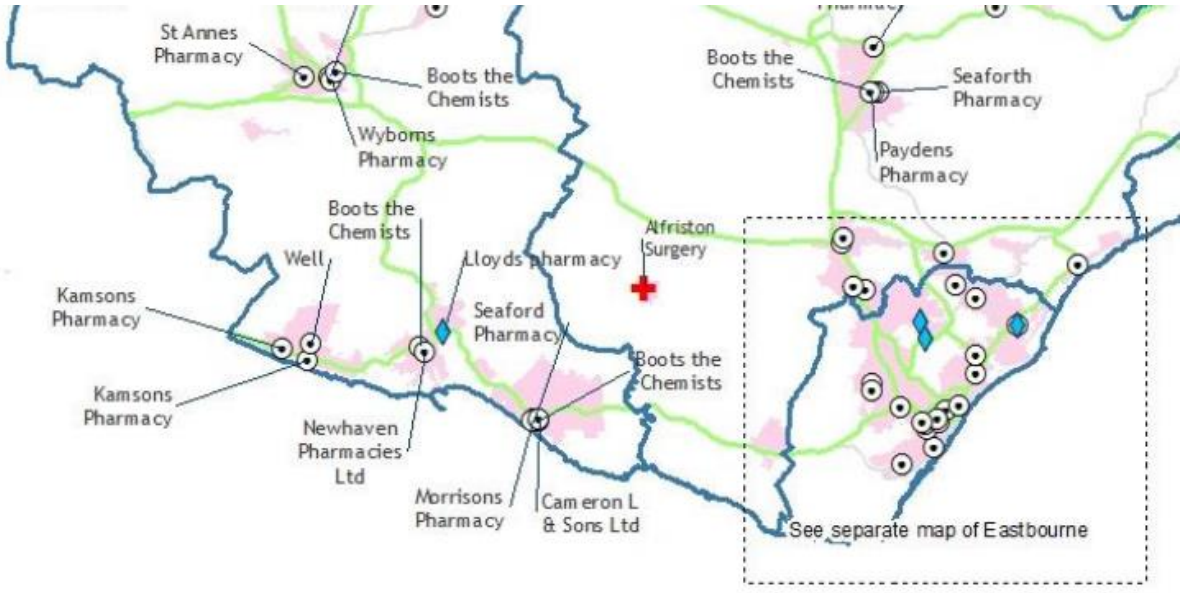
4.7 Some additional travel analyses [included with this paper in Appendix 1] were provided to the steering group after the meeting. Members of the steering group responded offering differing opinions in their feedback. Two members have stated no gap, and two others stated there would be a gap in services on Sundays.

Summary of steering group organisations views regarding Newhaven:

LPC	No gap
Medicines Management, Sussex ICB	No gap
Healthwatch	Gap
LMC	Gap [with reservations about new analyses]
Public Health, ESCC	Gap

4.8 Therefore, the majority opinion from the steering group is that there is a gap in access to services in Newhaven on a Sunday.

Map from PNA showing Lloyds pharmacy in Newhaven Town and neighbouring area (Figure 16 in PNA)



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5 Conclusions and recommendations

5.1 At the last HWB meeting on 7th March [Item 39] the Board was asked to approve the issuing of a Supplementary Statement following the closure of the Lloyds pharmacy in St Leonards. Following the PNA steering group meeting and clarification of the basis for issuing a Supplementary Statement, it was recommended that the Supplementary Statement for Hastings and St. Leonards was not required and should be removed.

5.2 The Board is recommended to approve the recommendations from PNA steering group of 26th April 2023 which were:

- No Supplementary Statement was required for Lloyds in Sainsburys, St Leonards. Therefore, agree to the retraction of the Supplementary Statement.
- No Supplementary Statement will be required for Lloyds in Sainsburys, Eastbourne.
- Approval of the Board for the issue of a Supplementary Statement for Lloyds in Sainsburys in Newhaven based on the majority opinion from the PNA steering group.

5.3 The Board is asked to note that there may be changes in service provision as a consequence of the amended NHS Pharmaceutical Regulations with regard to the opening hours of 100-hour pharmacies from 25th May 2023.

Darrell Gale
Director of Public Health

Contact Officer: Nick Kendall
Tel. No. 07523 930873
Email: nick.kendall@eastsussex.gov.uk

BACKGROUND DOCUMENTS

None.

Appendices

Appendix 1 - Travel Analyses undertaken in May 2023, provided to PNA Steering Group after April meeting.

Supplementary travel access analysis

May 2023

At the request of the PNA steering group, this summary will look at public transport access to community pharmacies on a Sunday before and after the imminent closure of the Lloyds pharmacy in Newhaven.

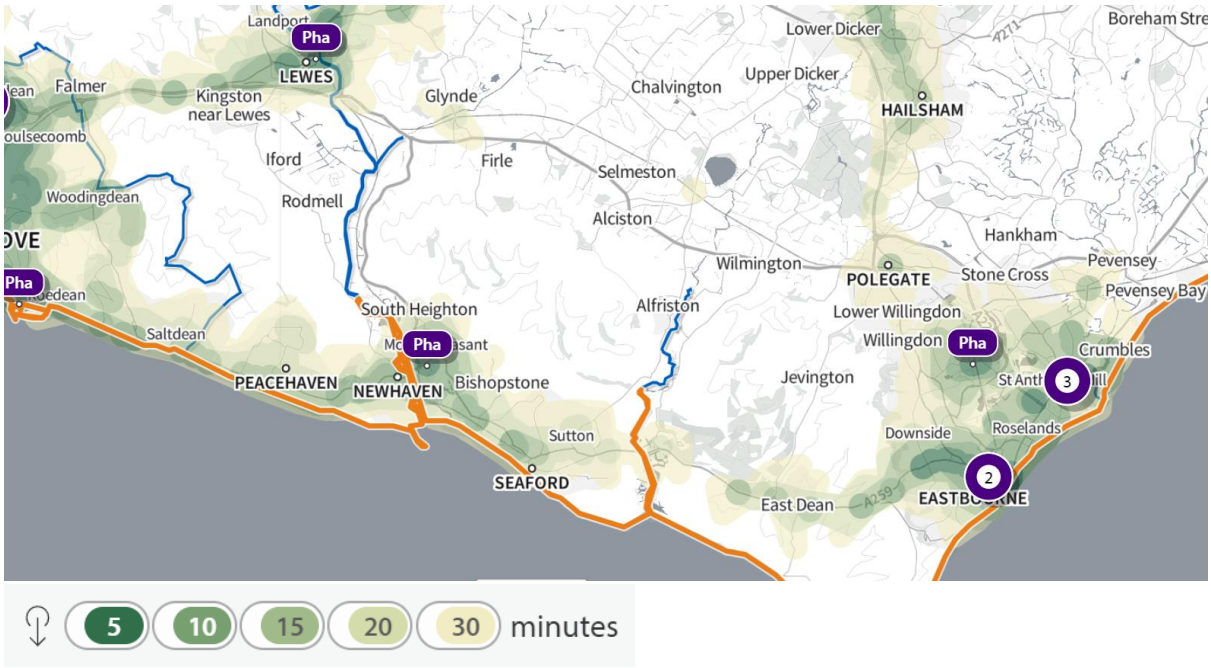
One of the criteria, agreed by the steering group for the PNA, for assessing access included 30 minutes travel time from an open pharmacy. Where car ownership was low (which included parts of Lewes district around Peacehaven, Newhaven and Seaford) it was important to consider public transport access.

> *Section 10.1 page 151*
>
> - The majority of the population should be within 30 minutes travel time of the above providers, so driving, walking and public transport time will be considered
> - Areas of low car ownership (where 15% or more of households are without cars) should be identified and examined for acceptable walking and / or public transport access

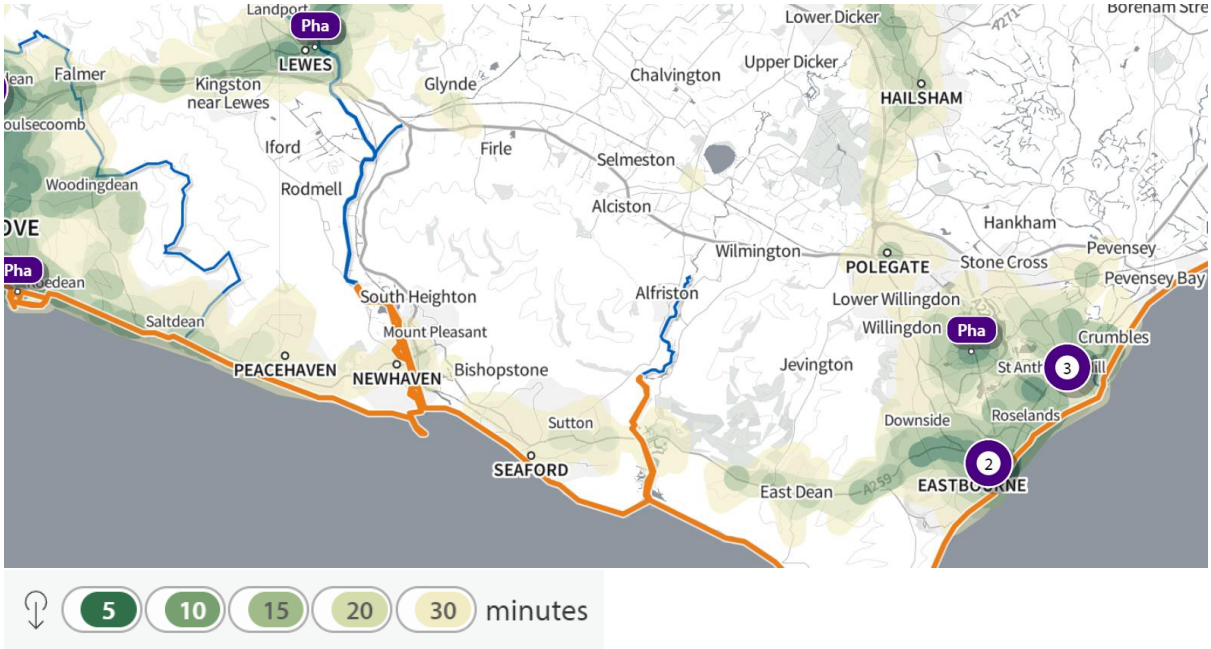
Unfortunately, it has not been possible to repeat the specific analyses undertaken in the PNA as the team who provided the analysis does not have capacity to assist. Therefore, we have used the SHAPE tool which is made available by the Department of Health and Social Care to support various workstreams, including the production of PNAs.

Whist the travel time element in SHAPE does not specifically look at Sunday travel times, it does provide a view for weekend mornings and weekend afternoons. We have looked at both of these periods in the maps below.

Map 1: Community pharmacies open on a Sunday **including Newhaven Lloyds**. Shaded areas reflect public transport travel times on a **weekend morning** to any open pharmacy.

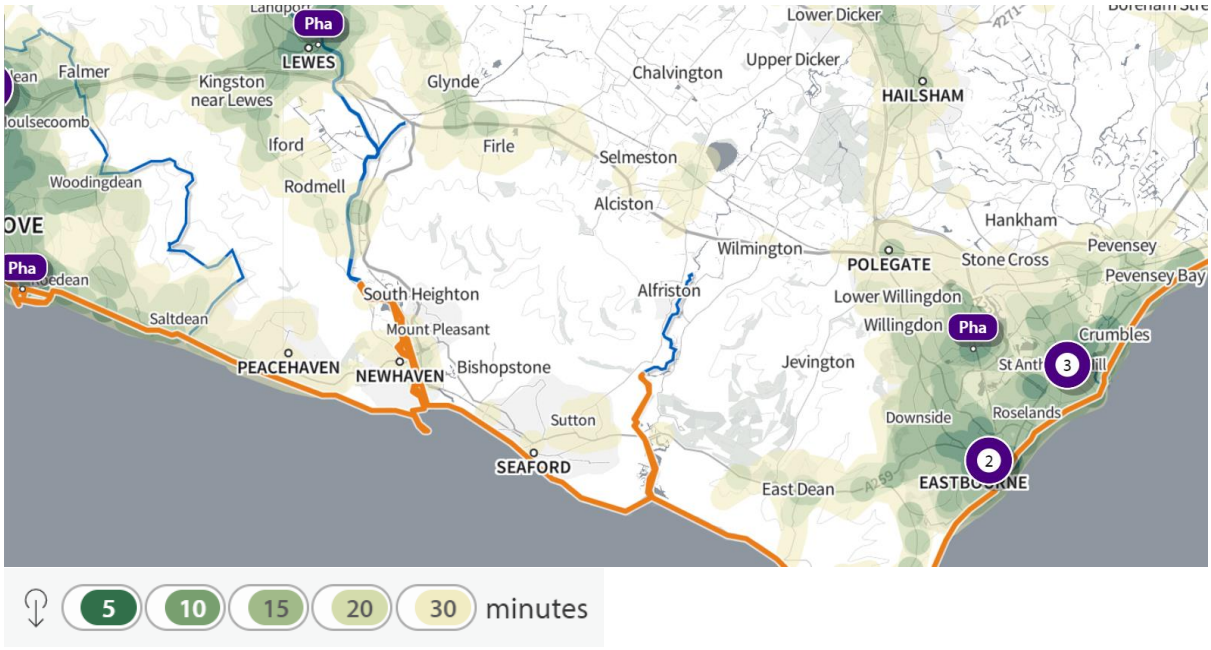


Map 2: Community pharmacies open on a Sunday **excluding Newhaven Lloyds**. Shaded areas reflect public transport travel times on a **weekend morning** to any open pharmacy.



Map 3: Community pharmacies open on a Sunday **including Newhaven Lloyds**. Shaded areas reflect public transport travel times on a **weekend afternoon** to any open pharmacy.

Map 4: Community pharmacies open on a Sunday **excluding Newhaven Lloyds**. Shaded areas reflect public transport travel times on a **weekend afternoon** to any open pharmacy.



Options to be considered by the steering group.

With the closure of Lloyds Newhaven on 13th June

1. No gap identified.
2. Gap identified, supplementary statement to be issued.
3. Gap identified, supplementary statement to be issued pending re-writing of the whole PNA.

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East Sussex Health and Wellbeing Board Work Programme

Date of Meeting	Report
18 July 2023	Director of Public Health Annual report
	Healthwatch Annual Report
	Sussex learning from lives and deaths (LeDeR) Annual report
28 September 2023	East Sussex Health and Social Care Programme - update report
	Safeguarding Adults Board (SAB) Annual Report 2022-23
	Creative health position paper – Public Health (Darrell Gale)
12 December 2023	East Sussex Health and Social Care Programme - update report
	East Sussex Safeguarding Children Partnership (ESSCP) Annual Report 2022-23
	Joint Strategic Needs Assessment (JSNA) Update report
TBC	NHS Health and Care Act (item from Cabinet agreeing MOU and formal participation in ICB).
TBC	Workshop meeting - to look at and agree milestones and Key Performance Indicators (KPIs) for monitoring on integrated health and social care partnership.
TBC	Children and Young People's Mental Health programme.

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